

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 28001

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death					
	Zella M. Boyle						September 3 2011	1005 AM					
Funeral Director	4a. Facility Name (if not institution, give street and number) Bel Air Health and Rehabilitation Center			4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford						
	5. Social Security Number 512-01-4271	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04/30/1920	9. Birthplace (State or Foreign Country) Missouri						
To Be Completed by Funeral Director	10a. State MD	10b. County Harford	10c. City, Town or Location Fallston					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 504 Summit Drive			10f. Zip Code 21047			10g. Citizen of What Country? U.S.A.						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 6 Teacher		16b. Kind of Business Industry Sedgewick County School System								
	17. Father's Name (First, Middle, Last) Lloyd J. Alkire				18. Mother's Name (First, Middle, Maiden Surname) Leota L. Lundy								
	19a. Informant's Name/Relationship (Type, Print) Barbara A. Steyer (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Summit Drive - Fallston, Maryland 21047								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► E. F. Lassahn			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 09/06/2011	20c. Location - City or Town, State Baltimore, Maryland						
	21. Signature of Funeral Service Licensee E. F. Lassahn				22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 weeks				
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Hypertension								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier Peter Colnisti, DO FACE			29c. License number H39022	29d. Date signed (Month, Day, Year) September 6 2011
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Colnisti, DO FACE 1308 Business Center Way Edgewater MD 21040								31. Date filed (Month, Day, Year) SEP 06 2011			32. Registrar's Signature Lorraine J. Farrel	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: "The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, Page 2 should be detached for use as the burial-transit once."

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 16a, per FRH, G919, 9/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28002

Reg. No.

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Item 27 is marked other than "natural"; or items 23a or 28a if show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 4:45P M	
Grace M. Beveridge		August 30 2011			
4a. Facility Name (If not institution, give street and number)  811 Bradley Road		4b. City, Town, or Location of Death  Joppa		4c. County of Death  Harford	
5. Social Security Number  220-14-8742		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)  96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
10a. State  MD		10b. County  Harford		10c. City, Town or Location  Joppa	
10e. Street and Number  811 Bradley Road		10f. Zip Code  21085		10g. Citizen of What Country?  U.S.A.	
11. Marital Status  1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  White	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  College (1-4 or 5+) 4		16b. Kind of Business/Industry  Family & Childrens Soc. Family & Children Soc.	
17. Father's Name (First, Middle, Last)  Thomas Monson		18. Mother's Name (First, Middle, Maiden Surname)  Amelia Tatum			
19a. Informant's Name/Relationship (Type, Print)  Donald Beveridge (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  811 Bradley Road - Joppa, Maryland 21085			
20a. Method of Disposition  1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Bel Air Memorial Gdns.		20b. Place of Disposition (Name of cemetery, crematory or other place)  Bel Air Memorial Gdns.		Date 09/03/2011	20c. Location - City or Town, State  Bel Air, Maryland
21. Signature of Funeral Service Licensee  ► E. F. Lassahn		22. Name and Address of Facility  E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. <u>atherosclerotic cardiovascular disease</u> Due to (or as a consequence of):</p> <p>b. <u>cardiomyopathy</u> Due to (or as a consequence of):</p> <p>c. <u>hypertension</u> Due to (or as a consequence of):</p> <p>d. _____</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 0043909			
29b. Signature and title of certifier ► Stephanie Linder MD		29d. Date signed (Month, Day, Year) August 31, 2011			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Linder 902 Averill Rd Joppa, MD 21085					
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Sandra S. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28003

Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jason Paul

Benfield, Sr.

2. Date of Death

Month Day Year  
August 25, 2011

3. Time of Death

1208P M

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department. If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
The John Hopkins Hospital	Baltimore City	None			
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 20, 1969	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Millersville			
10e. Street and Number 803 Mallet Hill Lane	10f. Zip Code 21108			10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner	16b. Kind of Business Industry Construction		
17. Father's Name (First, Middle, Last) Ronald Benfield			18. Mother's Name (First, Middle, Maiden Surname) Margaret Rogers Parker		
19a. Informant's Name/Relationship (Type, Print) Helen L. Benfield/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Mallet Hill Lane, Millersville, Maryland 21108			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park	Date August 31, 2011	20c. Location - City or Town, State Elkridge, Maryland	
21. Signature of Funeral Service Licensee ► [Signature]		22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113			

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <u>chronic myelomonocytic leukemia</u> Due to (or as a consequence of):				
b. <u>acute myeloid leukemia</u> Due to (or as a consequence of):				
c. <u>pneumonia</u> Due to (or as a consequence of):				
d. <u>acute respiratory distress syndrome</u>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier ► [Signature]		29c. License number Res - 000	29d. Date signed (Month, Day, Year) August 25, 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathryn A F Kline 609 N. Wolfe St. Baltimore MD 21287				
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Lena S. Parker		

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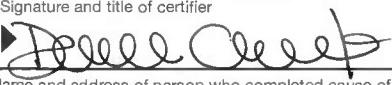
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28004

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ivan Ivanovych Bozhko</b>							2. Date of Death Month Day Year <b>September 1 2011</b>	3. Time of Death 15:49 PM	
	4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital of Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>			4c. County of Death		
Funeral Director	5. Social Security Number <b>219-77-8294</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Jan 2, 1935</b>	9. Birthplace (State or Foreign Country) <b>Ukraine</b>		
	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>6810 Park Heights Avenue</b>				10f. Zip Code <b>21215</b>			10g. Citizen of What Country? <b>Ukraine</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business Industry Education		
	17. Father's Name (First, Middle, Last) <b>Iva Bozhko</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Polina Yarez</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Valentyna S. Bozhko Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6810 Park Heights Avenue Apt 308 Balto. MD 21215</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Saints Cemetery</b>		Date <b>9/2/11</b>	20c. Location - City or Town, State <b>Reisterstown, MD</b>			
	21. Signature of Funeral Service Licensee <b>J Wayne Osterling</b>				22. Name and Address of Facility <b>ELINE FUNERAL HOME Reisterstown, MD 21136</b>					
Physician/ Medical Examiner	<p>23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Pulmonary Embolism</b> Due to (or as a consequence of):</p> <p>b. <b>Metastatic Renal Cell Carcinoma</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death <b>3 days</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>									
Medical Certificate: To Be Completed by Physician/Medical Examiner	<p>23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____</p>				<p>23d. Date of delivery Month Day Year</p>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier  <b>Danielle S. Chernick, MD</b>		29c. License number <b>RFS-000</b>		29d. Date signed (Month, Day, Year) <b>September 1, 2011</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Danielle S. Chernick, MD</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>							
			32. Registrar's Signature 							

Patient Known As Ivan Bozhko

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

**Division of Vital Records, P.O. Box 68760**

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

**amend item 9 per th g919 9-9-11 vt**  
 State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28005

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

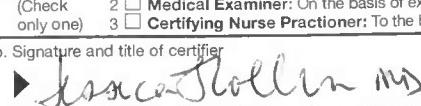
To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Baltimore, Maryland 21215-0036**

Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death			
Dario, Bernal	Month 09 Day 03 Year 2011	4:20 PM			
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Johns Hopkins Bayview Care Center	5505 Hopkins Bayview Hospital	Baltimore MD 21224			
5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) (Foreign Country)
154-98-3773	1 M 2 F	60 Yrs.		04/17/1951	Colombia
Usual Residence of Decedent			10d. Inside City Limits 1 □ Yes 2 <input checked="" type="checkbox"/> No		
10a. State	10b. County	10c. City, Town or Location			
VA	Fauquier	Remington			
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
7224 5th Street	22734	Venezuela			
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 □ Widowed 4 □ Divorced	1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input checked="" type="checkbox"/> Yes 2 □ No Specify:			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry		
Elementary/Secondary (0-12) 11		College (1-4 or 5+)	Self Employed	Truck Driver	
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Octavio Bernal			Maria Clara Sarmiento		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Patrizia Bernal Wife		7224 5th Street Remington, VA 22734			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State	
1 □ Burial 2 <input checked="" type="checkbox"/> Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Carroll Cremation	9/6/11	Hampstead, Maryland	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	11824 Reisterstown Road		
		ELINE FUNERAL HOME	Reisterstown, MD 21136		
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <u>Infiltrating astrocytoma (brain tumor)</u> 3 months					
b. _____ Due to (or as a consequence of): _____					
c. _____ Due to (or as a consequence of): _____					
d. _____					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 <input checked="" type="checkbox"/> No 3 □ Probably 4 □ Unknown					
25. Was case referred to medical examiner? 1 □ Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 □ Residence 6 □ Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D0067635		29d. Date signed (Month, Day, Year) SEPT 03 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Jessica Calburn, MD 4940 Eastern Ave Baltimore, MD 21224					
31. Date filed (Month, Year) SEP 03 2011		32. Registrar's Signature 			

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28006

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year September 2, 2011	3. Time of Death 0641 hrs
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Nathan Adom Buahin

4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	4c. County of Death Prince George's
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**Funeral  
Director**

5. Social Security Number 061-47-4419	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 24	If Under 1 Year Months 1	If Under 24 Hrs. Hours 24	Min.	8. Date of Birth (MM/DD/YYYY) July 9, 2011	9. Birthplace (State or Foreign Country) MD
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**To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23 or 28-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Laurel					

10e. Street and Number 295 Red Clay Road, Apt. 301	10f. Zip Code 20724	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. African-American Specify: American
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0	16b. Kind of Business/Industry none
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17. Father's Name (First, Middle, Last) Peter Ennin Buahin	18. Mother's Name (First, Middle, Maiden Surname) Brenda Oteng
---	---

19a. Informant's Name/Relationship (Type, Print) Peter E. Buahin/ Father	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 295 Red Clay Road, Apt. 301, Laurel, MD 20724
---	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: West Arundel Crem.	20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem.	Date Sept 5, 2011	20c. Location - City or Town, State Odenton, MD
--	--	----------------------	--

21. Signature of Funeral Service Licensee J. Ken Skiles	22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, MD 20707
--	--

**Physician  
/Medical  
Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

a. Immediate Cause (Final disease or condition resulting in death) Cardiac Rhabdomyoma	Due to (or as a consequence of):
---	----------------------------------

b.	Due to (or as a consequence of):
----	----------------------------------

c.	Due to (or as a consequence of):
----	----------------------------------

d.	Due to (or as a consequence of):
----	----------------------------------

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, per me, g922 12-1-11 sm	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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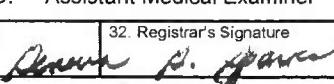
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 3, 2011
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30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature 
--	--

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

*Open*  
*-*

**State  
Registrar**

DHMH 17 Rev 1/2001

OCME 2006

**ORIGINAL****OCME**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28007

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Jean Adams Blake</b>				2. Date of Death Month <b>August</b> Day <b>23</b> , 2011 Year		3. Time of Death <b>1:51a</b> M	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director		5. Social Security Number <b>020-24-0975</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months      Days      Hours      Min.	8. Date of Birth (Month, Day, Year) <b>Apr 22, 1924</b>	9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director		10a. State <b>MD</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Adamstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>3200 Bakers Circle #A224</b>			10f. Zip Code <b>21710</b>		10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
		17. Father's Name (First, Middle, Last) <b>James Fairchild Adams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katharine Place</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Catherine C. Blake/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5707 Stony Run Drive Baltimore, MD 21210</b>				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Final Journey Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>08/29/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>		
		21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b> MO1251				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular Accident</b> Approximate Interval Between Onset and Death <b>1 week</b>							
		a. Due to (or as a consequence of): <b>Hypertension</b> 10 years							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month      Day      Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide							
		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No      28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier <b>Austin Pearre</b>							
		29c. License number <b>D09689</b>							
		29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Austin Pearre, M.D. 300 W. 9th Street Frederick, MD 21701</b>							
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Janice J. Jackson</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

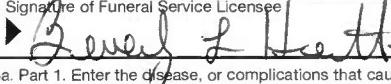
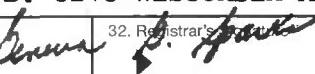
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28008

For  
State  
Register

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maxine B. Bjellos</b>					2. Date of Death Month Day Year <b>August 29, 2011</b>	3. Time of Death 0400 M
	4a. Facility Name (if not institution, give street and number) <b>Suburban Hospital</b>			4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>257-18-3695</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) <b>Nov 6, 1922</b>	9. Birthplace (State or Foreign Country) <b>Georgia</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2445 Lyttonsville Road</b>			10f. Zip Code <b>20910</b>			10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1 Homemaker		16b. Kind of Business Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>William Harvey Blount</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Belle Mills</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Diane B. Boyle/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9420 Singleton Drive Bethesda, MD 20817</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>09/02/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive Heart Failure</b>						
	a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. For Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	Approximate Interval Between Onset and Death						
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D26259</b>				
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>August 30, 2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ava Kaufman, M.D. 8218 Wisconsin Ave Bethesda, MD 20814</b>						
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's signature 				

MAXINE 08/29/11 0400  
Division of Vital Records, P.O. Box 68760  
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28009

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Alberta C. Broughton      2. Date of Death Month Day Year Aug. 22 2011      3. Time of Death 1:00 P M 4a. Facility Name (if not institution, give street and number) 6709 O'Donnell Street      4b. City, Town, or Location of Death Baltimore City      4c. County of Death N/A 5. Social Security Number 218-05-4207      6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F      7. Age (in yrs. last birthday) 90 Yrs.      8. Date of Birth (Month, Day, Year) March 21, 1921      9. Birthplace (State or Foreign Country) Maryland Usual Residence of Decedent 10a. State MD      10b. County N/A      10c. City, Town or Location Baltimore City      10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 10e. Street and Number 6709 O'Donnell Street      10f. Zip Code 21224      10g. Citizen of What Country? United States 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced      12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.      13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years      College (1-4 or 5+) 3 Years      16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk      16b. Kind of Business Industry Steel Industry 17. Father's Name (First, Middle, Last) Alfred E. Clasing      18. Mother's Name (First, Middle, Maiden Surname) Mary Neal 19a. Informant's Name/Relationship (Type, Print) (Grand) Brittaney Dziwulski (Daughter)      19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 O'Donnell Street Baltimore, Maryland 21224 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Oak Lawn Cemetery      20b. Place of Disposition (Name of cemetery, crematory or other place) Date 8/27/2011      20c. Location - City or Town, State Baltimore, Maryland 21. Signature of Funeral Service Licensee Doreen E. Reed      22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Due to (or as a consequence of): ASCVD b. Due to (or as a consequence of): CORD c. Due to (or as a consequence of): Diabetes d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Physician/ Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown      23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown      23d. Date of delivery Month Day Year							
Medical Certificate: To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 28a. Date of injury (Month, Day, Year)      28b. Time of injury M      28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No      28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)      28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Mukesh Luhar MD      29c. License number J0024303      29d. Date signed (Month, Day, Year) 08/23/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Luhar MD 3700 Fleet St. Suite 200 Baltimore, MD 21224 31. Date filed (Month, Day, Year) SEP 06 2011      32. Registrar's Signature James J. Park							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2011 28010

**Certificate of Death**

Reg. No.

## 1- For State Registrar

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Angelina Belinda Benjamin	August 9, 2011	1700 hrs

**Funeral Director**

4a. Facility Name (if not institution, give street and number) 426 North East Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A			
5. Social Security Number 219-72-6947	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 01/29/1958	9. Birthplace (State or Foreign Country) MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	
10e. Street and Number 426 East Ave.			10f. Zip Code 21224
10g. Citizen of What Country? U.S.A.			

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Substitute Teacher	16b. Kind of Business/Industry Baltimore City Public Schools
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17. Father's Name (First, Middle, Last) William Gresham	18. Mother's Name (First, Middle, Maiden Surname) Francis Grady
--	--

19a. Informant's Name/Relationship (Type, Print) Simon Benjamin (Husband)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 East Ave., Baltimore, MD 21224
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: on-site Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 08/25/11	20c. Location - City or Town, State Baltimore, MD
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21. Signature of Funeral Service Licensee <i>Dietrich N. Williams</i>	22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217
--	---

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d.			
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Laron Locke MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 10, 2011
--	--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
---

31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature <i>Debra J. Park</i>
--	---

**State Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28011  
Reg. No.1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>Anna Brockington</b>		2. Date of Death Month <b>AUG</b> Day <b>23</b> Year <b>2011</b>	3. Time of Death <b>16:00</b>
4a. Facility Name (if not institution, give street and number) <b>ST AGNES HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>	
4c. County of Death <b>N/A</b>		5. Social Security Number <b>216-24-3691</b>	
6. Sex <b>M</b>		7. Age (In yrs. last birthday) <b>93 Yrs.</b>	
8. Date of Birth <b>08/19/1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
10a. State <b>MD</b>		10b. County <b>N/A</b>	
10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <b>Yes</b>	
10e. Street and Number <b>2209 Penrose Ave.</b>		10f. Zip Code <b>21223</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>8th Grade</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business Industry <b>Private Families</b>	
17. Father's Name (First, Middle, Last) <b>Purnell Kelly</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary unk</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mary Glascock (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4001 Duvall Ave., Baltimore, MD 21216</b>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Cemetery</b>	
		Date <b>09/02/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee <b>Jacqueline S. Roane</b>		22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>13 DAYS</b>	
a. <b>HEPATIC CARCINOMA</b> Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>P24071</b>	
29b. Signature and title of certifier <b>M. Zilberman M.D.</b>		29d. Date signed (Month, Day, Year) <b>Aug 23, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mihail F. Zilberman, M.D.</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
32. Registrar's Signature <b>Laura J. Parks</b>			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28012

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Effie R. Bochniak</b>		2. Date of Death Month Day Year <b>August 29, 2011</b>	3. Time of Death <b>7:40 P.M.</b>
4a. Facility Name (if not institution, give street and number) <b>GenesisElderCare-Heritage</b>		4b. City, Town, or Location of Death <b>Dundalk</b>	4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>272-16-6409</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98 Yrs.</b>
		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
8a. Date of Birth Month/Day/Year <b>Apr 14, 1913</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>	
10a. State <b>Md.</b>		10b. County <b>Baltimore City</b>	
10c. City, Town or Location <b>Baltimore City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2528 Fleet Street</b>		10f. Zip Code <b>21224</b>	10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>	16b. Kind of Business Industry <b>Own Home</b>
17. Father's Name (First, Middle, Last) <b>Edward Rutherford</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Hardy</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Edward Bochniak / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>618 South Belnord Avenue Baltimore, Md 21224</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Robert [Signature]</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Stanislaus Cem.</b>	20c. Date of Disposition <b>September 2, 2011</b>
21. Signature of Funeral Service Licensee <b>► Robert [Signature]</b>		22. Name and Address of Facility <b>Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md. 21222</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b></p> <p>b. Due to (or as a consequence of): <b>HYPERTENSION</b></p> <p>c. Due to (or as a consequence of): <b>DEMENIA</b></p> <p>d. Due to (or as a consequence of): <b>MALNUTRITION</b></p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury
		28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D 27188</b>	
29b. Signature and title of certifier <b>► Savinder K. Julka MD</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Savinder K. Julka, M.D. 2 Market Place Dundalk, Maryland 21222</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
		32. Registrar's Signature <b>Savinder K. Julka</b>	

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28013

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last) <b>ELIZABETH CLARK</b>		2. Date of Death Month AUGUST Day 28 Year 2011	3. Time of Death 3:33 p M
4a. Facility Name (if not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>FREDERICK</b>	
5. Social Security Number <b>244-44-0086</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.
8. If Under 1 Year Months		If Under 24 Hrs. Days Hours Min.	
9. Birthplace (State or Foreign Country) <b>Clinton, SC</b>		10. County of Death <b>FREDERICK</b>	
11. Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Washington</b>	
10c. City, Town or Location <b>Boonsboro</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>20624 Buckskin Ct</b>		10f. Zip Code <b>21713</b>	
10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>	
16b. Kind of Business Industry <b>Private</b>			
17. Father's Name (First, Middle, Last) <b>Oscar Lee Dunlap</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mami McGowan</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Sheila Phang/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20624 Buckskin Ct. Boonsboro, MD 21713</b>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD National Park</b>	
21. Signature of Funeral Service Licensee ►		20c. Date <b>9/4/2011</b>	
21. Signature of Funeral Service Licensee ►		20c. Location - City or Town, State <b>Laurel, MD</b>	
22. Name and Address of Facility <b>Johnson &amp; Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. <b>bilateral Stroke</b> Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	
23d. Date of delivery Month Day Year			
24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier ► <i>Myung Hee Nam</i>		29c. License number <b>MDD 35106</b>	
29d. Date signed (Month, Day, Year) <b>8/28/2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Myung Hee Nam 400 W 1st St Frederick, MD 21701</b>			
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <i>Suzanne S. Paulson</i>	

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760**

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28014

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 21 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit one.

		1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death	
		MITCHELL D. COHEN			Month SEPTEMBER Day 01 Year 2011			07:15A M	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
		12 STRAWHILL COURT			OWINGS MILLS			BALTIMORE	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
		220-46-8973	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	57 Yrs.	Months	Days	(Month Day Year) 07/16/1954	MD	
To Be Completed by Funeral Director		Usual Residence of Decedent			10c. City, Town or Location			10d. Inside City Limits	
		10a. State MD	10b. County BALTIMORE	OWINGS MILLS			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Physician/ Medical Examiner		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
		12 STRAWHILL COURT			21117			USA	
To Be Completed by Physician/Medical Examiner		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: WHITE	
Medical Certificate: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry	
		Elementary/Secondary (0-12)			College (1-4 or 5+)			SENIOR ACCOUNT EXECUTIVE	
Physician/ Medical Examiner		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)				
		SIDNEY COHEN			GLORIA EPSTEIN				
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
		ELLEN COHEN/WIFE			12 STRAWHILL COURT, OWINGS MILLS, MD 21117				
Physician/ Medical Examiner		20a. Method of Disposition		20b. Place of Disposition (Name of Facility, if known, or name of place)		Date		20c. Location - City or Town, State	
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) GARRISON FOREST CEM.		OF CHIZUK AMUNO		09/04/2011		OWINGS MILLS, MD	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee			22. Name and Address of Facility				
		► Matt Le-			SOL LEVINSON & BROS., INC.				
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition resulting in death)							
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
		{ a. Due to (or is a consequence of): Cardiac arrhythmia b. Due to (or is a consequence of): left ventricular systolic dysfunction c. Due to (or is a consequence of): Coronary artery disease d. Due to (or is a consequence of): old myocardial infarct							
Physician/ Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
Physician/ Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D10613			29d. Date signed (Month, Day, Year) 9-2-2011		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit one.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAPHAEL PEREZ-MERA STE 222 1777 REISTERSTOWN RD							
State Registrar		31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Renee J. Perez					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #1 per FH G919 9/06/2011 TH  
 State of Maryland Department of Health and Mental Hygiene

2011 28015

## Certificate of Death

Reg. No.

## 1- For State Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Franklin Compton</b>						2. Date of Death Month Day Year August 27, 2011	3. Time of Death 0453 hrs	
	4a. Facility Name (if not institution, give street and number) 1021 Punjab Drive			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore County		
<b>Funeral Director</b>	5. Social Security Number <b>215-11-7335</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>40</b> Yrs.		If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Jan 2, 1971	8. Date of Birth (MM/DD/YYYY) <b>Jan 2, 1971</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	10a. State <b>MD</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Eden</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>31778 Flower Hill Church Rd#B</b>				10f. Zip Code <b>21822</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			14. Race - American Indian, Black, White, etc. <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>N/A</b>			16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Franklin Compton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dora May Lifferty</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Bobbie Compton/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31778 Flower Hill Church Rd Eden Md 21822</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey</b>			Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charisse N Woods F/S 2700 Edmondson Ave. Balt., MD 21223</b>					
<b>Physician / Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	a. <u>Complications of Torso Injuries</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death
<b>Medical Examiner</b>	<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g919 9-27-11 sm						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>fd 8-23-11</b>		28b. Time of Injury <b>Unknown</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject hit by vehicle</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>roadway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 50 Salisbury, Md.</b>							
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 27, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28016

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Min.
<i>Ianthe Cheates</i>		August 29 2011		07 15M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Northwest Hospital</i>		<i>Randallstown</i>		<i>Baltimore</i>
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
219-01-6623		88		
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore
10e. Street and Number 5606 Wayne Ave		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3yrs		16b. Kind of Business Industry Clerk C & P Telephone
17. Father's Name (First, Middle, Last) Russell Bailey		18. Mother's Name (First, Middle, Maiden Surname) Edith Gates		
19a. Informant's Name/Relationship (Type, Print) Ruth Harris-Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Wentworth Road, Baltimore, Md 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial		Date 9/3/2011
20c. Location - City or Town, State Arbutus, Md				
21. Signature of Funeral Service Licensee <i>Donald C. Shimp</i>		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death ASCVD
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D0062650</i>		29d. Date signed (Month, Day, Year) <i>August 29 2011</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Tanveer Garib 5401 1010 court road Randallstown MD 21133</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Laura B. Parker</i>

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28017

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28017

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>JOHN S. CALDER</b>			2. Date of Death Month Day Year <b>SEPTEMBER FIRST 2011</b>			3. Time of Death M <b>2:03 AM</b>	
4a. Facility Name (if not institution, give street and number) <b>HARBOR HOSPITAL</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore City</b>	
5. Social Security Number <b>217-46-3340</b>		6. Sex <b>1 X M 2 F</b>		7. Age (In yrs. last birthday) <b>80 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>02/25/1931</b>	
9. Birthplace (State or Foreign Country) <b>Canada</b>							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>			
10e. Street and Number <b>7911 Oakwood Road</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>Canada</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Supervisor Pressman</b>		16b. Kind of Business Industry <b>Printing</b>			
17. Father's Name (First, Middle, Last) <b>George Calder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Johanna Swanson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Helen M. Calder / wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7911 Oakwood Road, Glen Burnie, Maryland 21061</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>M01357</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>		Date <b>9/6/2011</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Mark L. Van</b>		22. Name and Address of Facility <b>1 2nd Ave, SW Glen Burnie, MD Singleton Funeral &amp; Cremation Services, P.A.</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
a. <b>CONGESTIVE HEART FAILURE class IV</b> Due to (or as a consequence of):							
b. <b>Ventricular Tachycardia</b> Due to (or as a consequence of):							
c. <b>Respiratory Failure</b> Due to (or as a consequence of):							
d. <b>Shock Liver</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No g <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>D R</b>		29c. License number <b>Res 001</b>		29d. Date signed (Month, Day, Year) <b>September First 2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DRAGOS BANU 3001 S. HANOVER STREET</b>							
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>J. Parker</b>					

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28018

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1935 hrs
Andrew Jackson Cox, Jr.	August 26, 2011	

**Funeral Director**

4a. Facility Name (if not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of Death Baltimore	4c. County of Death	
5. Social Security Number 212-58-4718	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY) March 11, 1952	9. Birthplace (State or Foreign Country) Maryland
---	--

**To Be Completed by Funeral Director**

10a. State MD	10b. County	10c. City, Town or Location Baltimore	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 4123 Audrey Avenue Apt. B		10f. Zip Code 21225	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Laborer
--	---	---

17. Father's Name (First, Middle, Last) Andrew Jackson Cox, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Flora Mae Troglin
--	--

19a. Informant's Name/Relationship (Type, Print) Jessica Ann O'Toole/friend	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7868 St. Claire Lane Dundalk, MD 21222
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey Crematory	Date 08/30/11	20c. Location - City or Town, State Woodbine, MD
--	---	------------------	---

21. Signature of Funeral Service Licensee <i>Beverly L. Heckrotte</i>	22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. <u>Dilated Cardiomyopathy</u> Due to (or as a consequence of):
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
--	--

c. Due to (or as a consequence of):	d.
--	----

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g919 9-8-11 sm
-----------------------------------	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

<u>Diabetes Mellitus</u>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
<u>Cocaine Use</u>	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
---

29b. Signature and title of certifier <i>Mary G. Ripple MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 27, 2011
---	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature <i>Mary G. Ripple</i>
--	--

**Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**State Registrar**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.** 2011 28019

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

**1. For State Registrar**

1. Decedent's Name (First, Middle, Last)

Tiran Jamar Carter Jr. Jr.

2. Date of Death

Month Day Year  
August 28, 2011

3. Time of Death

1231 hrs

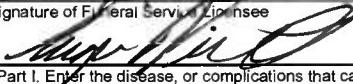
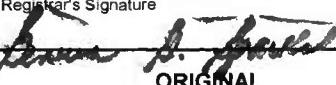
**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

<b>Physician/ Medical Examiner</b>		1. Decedent's Name (First, Middle, Last) <b>Tiran Jamar Carter Jr. Jr.</b>						2. Date of Death Month Day Year <b>August 28, 2011</b>		3. Time of Death <b>1231 hrs</b>		
<b>Funeral Director</b>		4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>				
		5. Social Security Number <b>242-91-4587</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>N/A</b>	If Under 1 Year Months <b>5</b>	If Under 24 Hrs. Days <b>Yrs.</b>	8. Date of Birth (MM/DD/YYYY) <b>3/25/2011</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
		10a. State <b>Md</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>Baltimore</b>				
		10e. Street and Number <b>3413 Ludgate Rd.</b>			10f. Zip Code <b>21215</b>			10g. Citizen of What Country? <b>USA</b>				
		11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>	14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>							
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) N/A</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) N/A</b>	16b. Kind of Business/Industry <b>N/A</b>								
		17. Father's Name (First, Middle, Last) <b>Tiran J. Carter, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Christina Newton</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Carolyn Newton-Grandmother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4312 Belair Rd. Baltimore, MD 21206</b>							
		20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Park</b>			Date <b>9/3/2011</b>	20c. Location - City or Town, State <b>Randallstown, MD</b>			
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>							
<b>Physician/ Medical Examiner</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>a. Sudden Unexplained Death In Infancy (SUDI)</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> <b>UNPENDED</b> <b>AMENDED 1,23a,27,28a-f, per me, g923 1-31-12 sm 1 per me g924 2-16-12 vt 5 per fh g 924 2-17-12 vt</b>									Approximate Interval Between Onset and Death	
		23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			23f. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>				
		25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:							
		27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day, Year) <b>fd 8-28-11</b>			28b. Time of Injury <b>fd 11:50 am</b>				
					28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			28d. Describe how injury occurred <b>unknown</b>				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found at home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3413 Ludgate Rd. Baltimore, MD</b>							
		29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>				
		30. Name and address of person who completed cause of death (Item 23a) <b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>										
<b>State Registrar</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature  <b>ORIGINAL</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per th g919 9-6-11 vt State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar amend items 2 per doc, 18 per th g920 10-3-11 vt Certificate of Death

Reg. No. 2011 28020

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lelia A. Carter</i>					2. Date of Death 25 Month August Day 25 Year 2011 3. Time of Death 1:30 A.M	
	4a. Facility Name (if not institution, give street and number) 5610 York Road Apt 304		4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 228-34-4875	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 04/07/1929	9. Birthplace (State or Foreign Country) VA	
To Be Completed by Funeral Director	10a. State MD	10b. County	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 5610 York Road Apt 304	10f. Zip Code 21212		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 12	16b. Kind of Business Industry Homemaker				
	17. Father's Name (First, Middle, Last) Frank Carter	18. Mother's Name (First, Middle, Maiden Name) Susan Currie Susan Currie Dorothy Flury					
	19a. Informant's Name/Relationship (Type, Print) Arnold Carter Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9514 Whitehurst Drive Owings Mills MD 21117					
Physician/ Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of crematory or cemetery or place) Atlantic Crem	Date 8/26/11	20c. Location - City or Town, State Glen Burnie MD			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Thomas Allen</i>	22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Due to (or as a consequence of): <i>Gallbladder Cancer</i>		Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):					
		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number DOOS7465		29d. Date signed (Month, Day, Year) 8/25/11			
	29b. Signature and title of certifier <i>Wrayapalmen J.</i>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S Rayapakse MD 2835 Smith JV S-203 Baltimore MD 21209						
	31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature <i>Leanne S. Parker</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend #27, per MD G919 9/6/11 TT

State of Maryland / Department of Health and Mental Hygiene

2011 28021

### *Certificate of Death*

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>George Anderson Curry Jr.</b>						2. Date of Death Month Day Year <b>August 15 2011 9:45 P M</b>		3. Time of Death			
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital of Baltimore</b>						4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>			
		5. Social Security Number <b>218-62-2658</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57 Yrs.</b>		If Under 1 Year Months Days Hours Min.		8. Date of Birth Month Day Year <b>09/24/1953</b>			
		Usual Residence of Decedent											
		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		10e. Street and Number <b>2805 Santa Fe Ave.</b>						10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrician</b>			16b. Kind of Business Industry <b>Self Employed</b>		
		17. Father's Name (First, Middle, Last) <b>George Anderson Curry Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Audrey Lee</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Tiffany Curry (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Milford Mill Rd., Pikesville, MD 21208</b>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>on-site Crematory</b>				Date <b>08/22/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>		
		21. Signature of Funeral Service Licensee <b>Jacqueline Roane</b>				22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Severe cardiomyopathy</b> Approximate Interval Between Onset and Death <b>9 days</b>											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atrial thrombus</b> Approximate Interval Between Onset and Death <b>9 days</b>											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Due to (or as a consequence of):</b> a. <b>Severe cardiomyopathy</b> b. <b>Atrial thrombus</b> c. _____ d. _____											
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b> <b>Acute Renal Failure</b> <b>Diabetes Mellitus</b>											
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
		24a. Was an autopsy performed? Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide											
		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier <b>Ajay Singh Hooda MD</b> 29c. License number <b>D 68705</b> 29d. Date signed (Month, Day, Year) <b>August 16, 2011</b>											
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AJAY SINGH HOODA</b> SINAI HOSPITAL OF BALTIMORE											
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Ajay Singh Hooda</b>									

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director page 2 should be detached for use as the burial and

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

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Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28022

Reg. No.

1. For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Czarski

2. Date of Death

Month

Day

Year

3. Time of Death

1655 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Maryland

Funeral  
Director5. Social Security Number  
213-36-41086. Sex  
1  M 2  F7. Age (in yrs. last birthday)  
73 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)  
Feb 28, 19389. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent:

10a. State  
Md.

10b. County

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

706 South Linwood Avenue

10f. Zip-Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1  Yes 2  No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes 2  No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

Clarence E. Larkin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Lehrer

19a. Informant's Name/Relationship (Type, Print)

Jerry Czarski - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 South Linwood Avenue Baltimore, Md 21224

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

August

20c. Location - City or Town, State

Bayview Crematory 29, 2011 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kaczorowski Funeral Home, PA

1201 Dundalk Avenue Baltimore, Md 21222

23a. Part 1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)Approximate  
Interval Between  
Onset and Death

3 days

- a.
- b.
- c.
- d.

3 months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical  
examiner?1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending  
2  Accident investigation  
3  Suicide 6  Could not be  
4  Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?

M

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(check only  
one)1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

August 26, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.DHMH 17 Rev 1/2001  
11595

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

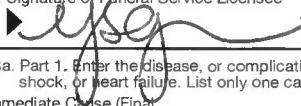
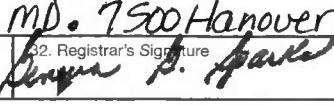
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28023

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>ESTHER L. DELAUER</b>		2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2011</b>	3. Time of Death <b>7:47PM</b>
4a. Facility Name (if not institution, give street and number) <b>DOCTOR'S HOSPITAL</b>		4b. City, Town, or Location of Death <b>LANHAM</b>	
4c. County of Death <b>PRINCE GEORGE'S</b>			
5. Social Security Number <b>578-58-4956</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>65</b> Yrs.
8. If Under 1 Year Months <b>0</b> Days <b>0</b>		If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	
9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
11. Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>LANDOVER</b>	
10e. Street and Number <b>3507 HUBBARD ROAD</b>		10f. Zip Code <b>20785</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HUMAN RESOURCE SPECIALIST</b>	16b. Kind of Business Industry <b>GOVERNMENT</b>
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LOUISE BROWN</b>	
19a. Informant's Name/Relationship (Type, Print) <b>REGINALD DELANDER/ SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 FORT MEADE RD #901 LAUREL, MARYLAND 20707</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HARMONY CEMETERY</b>	Date <b>9/9/2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME, INC.</b> <b>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
a. Due to (or as a consequence of): <b>COLON CANCER</b>			
b. Due to (or as a consequence of): <b>BRAIN AND LUNG METASTASIS</b>			
c. Due to (or as a consequence of): <b>DIABETES MELLITUS</b>			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month <b>0</b> Day <b>0</b> Year <b>0</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>MOD 58182</b>	
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>08/31/11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cecil D. George, md. 7500 Hanover Parkway, Suite 101A, Greenbelt, MD. 20710</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
		32. Registrar's Signature 	

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28024

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 1:30 PM
<b>William Edward Diffendal</b>		August 27 2011		
4a. Facility Name (if not institution, give street and number) <b>Hammonds Lane Center</b>		4b. City, Town, or Location of Death <b>Brooklyn Park</b>		4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>219013097</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>June 16, 1920</b>
9. Birthplace (State or Foreign Country) <b>MD</b>		10d. Inside City Limits <b>Yes</b> 2 <b>No</b>		
Usual Residence of Decedent <b>MD Anne Arundel</b>		10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Baltimore</b>		
10e. Street and Number <b>636 Sunset Strip</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dental Lab</b>		16b. Kind of Business Industry <b>Dental</b>
17. Father's Name (First, Middle, Last) <b>UNK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>UNK</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Terry Decker / granddaughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17103 Paps Lane Hagerstown, MD 21740</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Greenwood Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenwood Crematory</b>		Date <b>UNK</b> 20c. Location - City or Town, State <b>Allentown, PA 18434</b>
21. Signature of Funeral Service Licensee <b>Geno Decker</b>		22. Name and Address of Facility <b>JAM 1232 Midvalley Dr Jessup, PA</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>5 years</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <b>Chronic obstructive lung disease</b>		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Rani S. Karipineni</b>		
		29c. License number <b>D26307</b>		29d. Date signed (Month, Day, Year) <b>8/31/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rani Karipineni 202 West Maple Rd Linthicum, MD</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Doctor's Signature <b>Rani S. Karipineni</b>		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

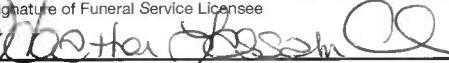
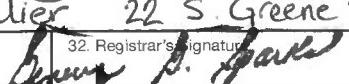
State of Maryland / Department of Health and Mental Hygiene

2011 28025

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Louise Drayer</b>				2. Date of Death Month <b>08</b> Day <b>31</b> Year <b>2011</b>	3. Time of Death <b>9:16 AM</b>				
	4a. Facility Name (if not institution, give street and number) <b>University of Maryland Medical Center</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>Baltimore City</b>					
Funeral Director	5. Social Security Number <b>213-38-7129</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months      Days	If Under 24 Hrs. Hours      Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 1, 1940</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Deal Island</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>23196 Soundside Estates Rd.</b>			10f. Zip Code <b>21821</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business Industry <b>Education</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>John F. Drayer (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23196 Soundside Estates Rd. Deal Island, Md. 21821</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy L. Gable</b>					
Physician Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>9-7-2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>							
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>							Approximate Interval Between Onset and Death <b>25 days</b>		
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Pneumonia</b>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month      Day      Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 		29c. License number <b>R131571</b>			29d. Date signed (Month, Day, Year) <b>8/31/2011</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Low-Ellen A. Lallier 22 S. Greene St. Baltimore, MD</b>										
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's signature 								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28026

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>RUTH LEE DEMBY</b>			2. Date of Death Month Day Year <b>August 24, 2011</b>	3. Time of Death 7:31 P.M.
4a. Facility Name (if not institution, give street and number) <b>Laurel Regional Hospital</b>			4b. City, Town, or Location of Death <b>Laurel</b>	
4c. County of Death <b>Prince George's</b>				
5. Social Security Number <b>199-18-3200</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth Month Day Year <b>Oct. 31, 1923</b>
9. Birthplace (State or Foreign Country) <b>PA</b>				
10a. State <b>MD</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Laurel</b>	
10e. Street and Number <b>9272-72 Cherry Lane</b>			10f. Zip Code <b>20708</b>	10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 2 years Communicator Officer</b>		16b. Kind of Business Industry <b>United States Postal Service</b>
17. Father's Name (First, Middle, Last) <b>Simon Hight</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Esther Southerland</b>	
19a. Informant's Name/Relationship (Type, Print) <b>James R. Demby / spouse</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9272-72 Cherry Lane Laurel, Maryland 20708</b>	
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>	Date <b>9/8/2011</b>
21. Signature of Funeral Service Licensee <b>G. S. Hight / M00770</b>			22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707</b>	

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death <b>1 Hr.</b>
<p>a. Due to (or as a consequence of):  <b>Acute Myocardial Infarction</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>	
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D 23685</b>	
29b. Signature and title of certifier <b>Peter Hammond, MD</b>		29d. Date signed (Month, Day, Year) <b>August 24, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter Hammond, MD Laurel Regional Hospital, Emergency Dept.</b>		7300 Van Dusen Rd. Laurel, MD 20707	
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Susan J. Harrel</b>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28027

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	DAVIS	2. Date of Death Month Day Year	3. Time of Death
Walter		August 24 2011	0008 M

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	Baltimore City

Funeral  
Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	8. If Under 1 Year Months Days Hours Min.	9. If Under 24 Hrs. Hours Min.	10. Date of Birth (Month, Day, Year) Aug 9, 1925	11. Birthplace (State or Foreign Country) MD
214-20-8886						

Usual Residence of Decedent  
10a. State MD  
10b. County Howard  
10c. City, Town or Location Ellicott City  
10d. Inside City Limits  
 Yes 2  No

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10e. Street and Number 3959 Old Columbia Pike	10f. Zip Code 21043	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1944 If Yes, Give Year or Dates. 1947	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1	16b. Kind of Business Industry Engineer
---	--	--

17. Father's Name (First, Middle, Last) Walter Lee Davis	18. Mother's Name (First, Middle, Maiden Surname) Hannah Pauline Sipe
---	--

19a. Informant's Name/Relationship (Type, Print) Roberta Davis	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3959 Old Columbia Pike Ellicott City, MD 21043
---	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mark's Cemetery	Date Aug 27, 2011	20c. Location - City or Town, State Highland, Maryland
--	---	----------------------	---

21. Signature of Funeral Service Licensee Cynthia Lee Moore 35	22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043
---	--

Physician  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. Myocardial Ischemia Due to (or as a consequence of):	
b. Coronary artery disease Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier ► Jessica Nguyen-Trong	29c. License number RES-000	29d. Date signed (Month, Day, Year) August 24 2011
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessica Nguyen-Trong	31. Date (Month, Day, Year) SEP 06 2011	32. Registrar's Signature ► Jennifer S. Powell
--	--	---

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

6x1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28028

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Warren DeLand</b>					2. Date of Death Month Day Year <b>August 28, 2011</b>	3. Time of Death <b>2:00 A M</b>			
	4a. Facility Name (if not institution, give street and number) <b>6542 Bellevue Drive</b>			4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>				
Funeral Director	5. Social Security Number <b>012-24-6570</b>	6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) <b>Apr 10, 1932</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>			
	10a. State <b>MD</b>			10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>				
10e. Street and Number <b>6542 Bellevue Drive</b>				10f. Zip Code <b>21046</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>1 □ Never Married 2 X Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 □ No</b> If Yes, Give Year or Dates <b>1950-58</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No</b> Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>6</b> <b>Mathematician</b>			16b. Kind of Business/Industry <b>Dept of Defense</b>				
17. Father's Name (First, Middle, Last) <b>Warren Albert DeLand</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Mae Bishop</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Marilyn Marshall DeLand/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6542 Bellevue Drive Columbia, MD 21046</b>							
20a. Method of Disposition <b>1 □ Burial 2 X Cremation 3 □ Removal from State</b> 4 □ Donation 5 □ Other (Specify) <b>Final Journey Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>			Date <b>08/30/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>			
21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b>				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784</b> <b>M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
<p>a. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown		
								24a. Was an autopsy performed? 1 □ Yes 2 X No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)								
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <b>Nicholas W. Koutrelakos, M.D.</b>		
								29c. License number <b>D38509</b>		
								29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nicholas W. Koutrelakos, M.D. 10710 Charter Dr. Suite G020 Columbia, MD 21044</b>								31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		
								32. Registrar's Signature <b>Leanne D. Parker</b>		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10x1  
State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28029

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 2 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 09 Day 01 Year 2011				3. Time of Death 1530 M	
Helen Louise Duckett							
4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
5. Social Security Number 463-80-6970		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 05/24/1949	9. Birthplace (State or Foreign Country) Texas
Usual Residence of Decedent		10a. State MD 10b. County Prince George's 10c. City, Town or Location Forestville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2100 Brooks Drive #210		10f. Zip Code 20747				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business Industry Management Analyst			Government
17. Father's Name (First, Middle, Last) Jimmie Butler, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Annie Ford					
19a. Informant's Name/Relationship (Type, Print) Loretta Lang (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5324 Foxglove Drive, Bossier City, LA 71112					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) East Lawn Cemetery		Date 9/10/2011	20c. Location - City or Town, State Wichita Falls, TX		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. <b>Endocarditis</b> Due to (or as a consequence of):							
b. <b>Sepsis</b> Due to (or as a consequence of):							
c. <b>Pneumonia</b> Due to (or as a consequence of):							
d. <b>Systematic Lupus Erythematosus</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D63639				29d. Date signed (Month, Day, Year) 09/02/2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTLU RAJU NAGABHRYU, MD 1500 Forest Glen Rd., Silver Spring							
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature 					

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 28030

1- For State Amend Item 25 per me, g918, 08/31/2011 dhb  
State of Maryland / Department of Health and Mental Hygiene  
Registrar Certificate of Death Reg. No.

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Eddie Drake</i>							2. Date of Death Month Day Year <i>08 21 2011</i>	3. Time of Death 08:30 AM
	4a. Facility Name (if not institution, give street and number) <i>Seasons Hospice of Baltimore</i>			4b. City, Town, or Location of Death <i>Randellstown, MD</i>			4c. County of Death <i>Baltimore</i>		
<b>Funeral Director</b>	5. Social Security Number <i>216-34-4666</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month Day Year <i>03/03/1937</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <i>MD</i>		10b. County <i>Baltimore Co.</i>		10c. City, Town or Location <i>Windsor Mill</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>7478 Catterick Ct.</i>			10f. Zip Code <i>21244</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11th Grade</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i>		16b. Kind of Business Industry <i>Operator (Bin Tower)</i>			16c. Kind of Business Industry <i>Domino Sugar</i>	
	17. Father's Name (First, Middle, Last) <i>Eddie L. Drake</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Annie Parham</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Denise Drake (wife)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7478 Catterick Ct., Windsor Mill, MD 21244</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest</i>		Date <i>08/30/11</i>	20c. Location - City or Town, State <i>Owings Mills, MD</i>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</i>						
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Intracerebral hemorrhage</i>								Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): <i>[Signature]</i>								
	c. Due to (or as a consequence of): <i>[Signature]</i>								
	d. Due to (or as a consequence of): <i>[Signature]</i>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Inpatient hospice</i>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier <i>[Signature] D.O.</i>		29c. License number <i>H64261</i>			29d. Date signed (Month, Day, Year) <i>8/21/2011</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Betty Wang 6190 Georgetown Blvd., Eldersburg MD 21784</i>								
	31. Date filed (Month, Day, Year) <i>AUG 31 2011</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28031

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERARD DURKIE</b>							2. Date of Death Month <b>08</b> Day <b>28</b> Year <b>2011</b>	3. Time of Death <b>6:00P M</b>			
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN Hosp</b>							4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>217-09-3101</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months <b>05</b>	If Under 24 Hrs. Days <b>23</b>	Hours <b>00</b>	Min. <b>00</b>	8. Date of Birth (Month, Day, Year) <b>05/23/1919</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>					10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>3409 Lambros Road</b>				10f. Zip Code <b>21234</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>1941-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry							
	17. Father's Name (First, Middle, Last) <b>Adam F.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Durkie, Sr. Eleanora</b>					<b>Woldreck</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary L. Fitzgerald, Step-Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3409 Lambros Road, Baltimore, MD 21234</b>								
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>			Date <b>09/01/2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Alexandra Blair</b>			22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>fat embolism</b>			Approximate Interval Between Onset and Death <b>days</b>								
	23b. Was decedent pregnant in the past 12 months? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b>						23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			23f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3409 Lambros Rd</b>								
	24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>								
	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>								
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day, Year) <b>unknown unknown</b>			28b. Time of Injury <b>unknown</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>unknown</b>			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3409 Lambros Rd</b>								
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>			29c. License number <b>RES 000</b>						29d. Date signed (Month, Day, Year) <b>08/30/2011</b>		
	29b. Signature and title of certifier <b>L. Syle</b>											
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S601 LOCH RAVEN BLVD, BALTIMORE MD</b>			32. Registrar's Signature <b>J. Parker</b>								
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, WJ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

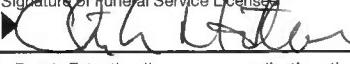
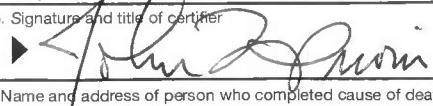
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28032

1- For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Leon A. Draper</b>				2. Date of Death Month <b>August</b> Day <b>25</b> , Year <b>2011</b>	3. Time of Death <b>7:30 A.M.</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Joseph Ritchie Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death <b>N/A</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>212-48-0929</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <b>October 14, 1946</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number <b>6020 Amber Wood Road Apt. B4</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Campus security</b>			16b. Kind of Business Industry <b>Johns Hopkins University</b>		
		17. Father's Name (First, Middle, Last) <b>Henry Billups</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Draper</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Lorrie Richardson/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8179 Gray Haven Road Baltimore Maryland 21222</b>			
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>	Date <b>8/26/11</b>	20c. Location - City or Town, State <b>Towson Maryland</b>	
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John J. Ruck, Inc.</b> <b>5305 Harford Road Baltimore Maryland 21214</b>			
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>4 months</b>			
		<p>a. Due to (or as a consequence of): <b>End stage liver disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatitis C</b> <b>Alcoholism</b> <b>Diabetes</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>			
		27. Manner of Death <b>1 Natural</b> <b>5 Pending Investigation</b> <b>2 Accident</b> <b>6 Could not be determined</b> <b>3 Suicide</b> <b>4 Homicide</b>		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
		29c. License number <b>056211</b>				29d. Date signed (Month, Day, Year) <b>8/25/11</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John F. Irwin, MD 3001 S. Hanover St. Baltimore, MD 21225</b>							
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Leen A. Draper 7:30 am  
Division of Vital Records, P.O. Box 68760 As.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28033

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death		
ERWIN DEITCH							Month AUGUST Day 30, Year 2011	6:50 PM		
4a. Facility Name (if not institution, give street and number)							4b. City, Town, or Location of Death		4c. County of Death	
GILCHRIST HOSPICE CARE							TOWSON		BALTIMORE	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)			If Under 1 Year Months		If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-5220		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	84 Yrs.						02/21/1927	MD
Usual Residence of Decedent										
10a. State	10b. County		10c. City, Town or Location						10d. Inside City Limits	
MD	BALTIMORE		BALTIMORE						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
2 POMONA EAST, APT. 607				21208				USA		
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12)			College (1-4 or 5+)			OWNER			CROSS COUNTRY PHARMACY	
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)					
HARRY DEITCH					REBA COHEN					
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
JOAN DEITCH/WIFE				2 POMONA EAST, APT. 607, BALTIMORE, MD 21208						
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, cemetery or other place)			Date	20c. Location - City or Town, State		
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				ARLINGTON CHIZUK AMUNO CEMETERY			09/02/2011	BALTIMORE, MD		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility						
				SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208						

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)												DAYS	
a. <u>CORONAROVASCULAR ACCIDENT</u> Due to (or as a consequence of):													
b. <u>HYPERTENSION</u> Due to (or as a consequence of):												YEARS	
c. _____ Due to (or as a consequence of):													
d. _____													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown										23d. Date of delivery	
												Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23e. Did tobacco use contribute to the cause of death?	
<u>LUNG CANCER</u> <u>LIVER CANCER</u>												<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)										23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>HOSPITAL</u>											
27. Manner of Death		28a. Date of injury (Month, Day, Year)			28b. Time of injury		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					M								
29a. Certifier		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29c. License number										29d. Date signed (Month, Day, Year)	
<u>MICHAEL J. ALEXANDER MD</u> 6701 North Charles Street Baltimore MD		<u>DA6360</u>										<u>August 30, 2011</u>	
31. Date filed (Month, Day, Year)		32. Registrar's Signature											
SEP 06 2011		<u>Jeanne J. Parker</u>											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28034

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 25a or 28a+ show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

## Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Frank W. Demski		Sept 01 2011		1:45 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Levindale		Baltimore City			
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 17, 1934
217-30-4443		76 Yrs.			9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State Md.	10b. County	10c. City, Town or Location Baltimore City			
10e. Street and Number 3015 Mardel Avenue		10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tow Truck Driver			16b. Kind of Business/Industry Towing
17. Father's Name (First, Middle, Last) Joseph Demski			18. Mother's Name (First, Middle, Maiden Surname) Mary Javorski		
19a. Informant's Name/Relationship (Type. Print) Veronica Robey/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Linda Avenue Linthicum Heights, Md 21090			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem		Date September 7, 2011	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee ► Tu		22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, Md. 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac arrhythmia</b> Immediate Cause (Final disease or condition resulting in death) <span style="float: right;">Approximate Interval Between Onset and Death ≤ 30 min</span> a. Due to (or as a consequence of): <b>Atherosclerotic cardiovascular disease</b> > 6 months b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End stage renal disease on hemodialysis, hypertension, Diabetes</b> 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0053928			
29b. Signature and title of certifier ► Regan, MD		29d. Date signed (Month, Day, Year) 09/01/2011			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BEGUM, MD 2434 W. BELVEDERE AVENUE, BALTIMORE, MD - 21215					
31. Date filed (Month Day Year) SEP 06 2011		32. Registrar's Signature Suzanne J. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28035

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death	3. Time of Death		
	David Albert Durham				Month August Day 29, 2011 Year	7:35 P.M.		
Funeral Director	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death		
	Stella Maris Hospice			Timonium		Baltimore		
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	215-92-4858	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	47 Yrs.			Oct 6, 1963	Maryland	
	Usual Residence of Decedent							
	10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	Md.	Baltimore	Middle River					
	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?		
	204 Midlass Drive, Apt. 1B			21220		U.S.A.		
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. American Indian
	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry			
	Elementary/Secondary (0-12) 12th		College (1-4 or 5+)		Truck Driver			Transportation
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
Arthur Durham				Kelliner Deese				
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Tracey Durham - Wife				204 Midlass Drive Baltimore, Md. 21220				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		September 1, 2011		20c. Location - City or Town, State		
Oak Lawn Cemetery						Baltimore, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Kaczorowski Funeral Home, P.A.</b> 1201 Dundalk Avenue Baltimore, Md. 21222						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)							
	a. <b>ENDOCRINE CANCER</b> Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>R149792</b>		29d. Date signed (Month, Day, Year) <b>8/30/2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
<b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 						

ORIGINAL

AUGUST 29, 2011 7:35 p.m.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #20b&c Per FH 9/14/2011 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28036

1 For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Year		3. Time of Death M: H: S
<i>George Emmons</i>		<i>August 31, 2011</i>		<i>7:10 PM</i>
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>2121 Windsor Garden Ln., Apt. 311-A</i>		<i>Baltimore</i>		
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86</i> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth Month Day Year <i>7-16-1925</i>
				9. Birthplace (State or Foreign Country) <i>NC</i>
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>2121 Windsor Garden Ln., Apt 311-A</i>		10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Self Employed</i>		16b. Kind of Business Industry <i>Trucking</i>
17. Father's Name (First, Middle, Last) <i>Pink Powell</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Zellie Ellis</i>		
19a. Informant's Name/ Relationship (Type, Print) <i>Deborah Alexander (Daughter)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1008 W. Franklin St, Balto., MD 21223</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of facility, if known) <i>Garrison Forest Cem.</i>		Date <i>9/12/11</i>
21. Signature of Funeral Service Licensee <i>Vaughn C. Fisher</i>		22. Name and address of Facility <i>Vaughn C. Greene Funeral Services 5151 Balto. Nat'l Pike (21229)</i>		28c. Location - City or Town, State <i>Gwynns Mills, MD</i>
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <i>Cardiac Arrhythmia</i> . Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>P25618</i>		
29b. Signature and title of certifier <i>Lydia Fisher, MO (FISHER)</i>		29d. Date signed (Month, Day, Year) <i>September 1, 2011</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LYDIA FISHER 22. South Greene Street, Baltimore, MD 21201</i>				
31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>James S. Pace</i>		

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28037

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Betty Elefante</b>			2. Date of Death Month September Day 4 Year 2011	3. Time of Death 2:14 AM
4a. Facility Name (if not institution, give street and number) <b>5774 Utrecht Rd.</b>			4b. City, Town, or Location of Death <b>Baltimore</b>	
5. Social Security Number <b>21944605G</b>			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63 Yrs.</b>
8. If Under 1 Year Months      Days			If Under 24 Hrs. Hours      Min.	
9. Date of Birth (Month, Day, Year) <b>04. 9 1947</b>			10. County of Death <b>N/A</b>	
11. Usual Residence of Decedent 10a. State <b>MD</b>			10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>
10e. Street and Number <b>5774 Utrecht Rd.</b>			10f. Zip Code <b>21206</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife	
16b. Kind of Business Industry <b>Home</b>				
17. Father's Name (First, Middle, Last) <b>Willie J. Turner</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Corraubay</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Lido Elefante - husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5774 Utrecht Rd. Baltimore, MD 21206</b>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>	Date <b>9-6-11</b>
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State <b>Catonsville, MD</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23b. Due to (or as a consequence of): <b>Myelodysplastic Syndrome</b> Approximate Interval Between Onset and Death <b>13 years</b>	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) M	28b. Time of injury M
			28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 			29c. License number <b>D15546</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles Padgett Jr.</b>			29d. Date signed (Month, Day, Year) <b>9-6-2011</b>	
31. Date filed (Month, Day, Year) <b>SFP 06 2011</b>			32. Registrar's Signature 	

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

## Medical Certificate: To Be Completed by Physician/Medical Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Neurofibromatosis</b>				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>D15546</b>		29d. Date signed (Month, Day, Year) <b>9-6-2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles Padgett Jr.</b>				
31. Date filed (Month, Day, Year) <b>SFP 06 2011</b>		32. Registrar's Signature 		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend Items 23aPtII, 25 per me, g981, 08/31/2011dhb Certificate of Death

Reg. No. 2011 28038

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Linda L. Edwards</b>				2. Date of Death Month AUGUST Day 06 Year 2011		3. Time of Death 08:11 P M					
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>214-62-2035</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Aug 12 1954</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
		Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Anne Arundel</b>							
		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		10e. Street and Number <b>232 Pindell Ave</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>Elementary/Secondary (0-12) 12th</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Service Specialist</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT USE RELIEF) <b>Service Specialist</b>		16b. Kind of Business Industry <b>American General Finance Co.</b>							
		17. Father's Name (First, Middle, Last) <b>Alfred T. Edwards Jr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn D. Wells</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Marneek Brown (Daughter)</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory</b>		Date <b>8-12-11</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>						
		21. Signature of Funeral Service Licensee <b>Wm. Reese &amp; Sons Mortuary, P.A.</b>				22. Name and Address of Facility <b>1922 Forest Dr. Annapolis, Md. 21401</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE RESPIRATORY DISTRESS</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>SEPTIC SHOCK</b> <b>ASPIRATION PNEUMONITIS</b> Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>3 DAYS</b>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, ACUTE KIDNEY INJURY, due to PAUCI-IMMUNE GLOMERULONEPHRITIS, DIABETES</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier <b>Vijay Joshi</b>								29c. License number <b>KES-000</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 06 2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRIJEN L. JOSHI, MD SINAI HOSPITAL OF BALTIMORE</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>		32. Registrar's Signature <b>Leanne S. Parker</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28039

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last) <i>Gladys Earp</i>							2. Date of Death Month <input checked="" type="checkbox"/> 8 Day <input type="checkbox"/> 26 Year <input type="checkbox"/> 2011 3. Time of Death <input type="checkbox"/> 03:20 AM	
4a. Facility Name (if not institution, give street and number) <i>Crofton Convalescent Care</i>							4b. City, Town, or Location of Death <i>Crofton</i>	4c. County of Death <i>Anne Arundel</i>
5. Social Security Number <b>230-28-6671</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 1, 1925</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3248 LEVERTON AVENUE</b>				10f. Zip Code <b>21224</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHERS AIDE</b>		16b. Kind of Business Industry <b>EDUCATION</b>				
17. Father's Name (First, Middle, Last) <b>ISAAC BENTON BOLLING</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY COLLIER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JUNE VANCE/ DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>529 KINGS MALCOLM AVE., ODETON, MD 21113</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other/Specify				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		Date <b>9/2/11</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <i>Atherosclerotic cerebrovascular disease</i>				
<p>a. Due to (or as a consequence of):               b. Due to (or as a consequence of):            c. Due to (or as a consequence of):            d. _____</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>R104317</b>		29d. Date signed (Month, Day, Year) <b>08/29/2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Diana Ng 2007 Tidewater Colony Dr. 1-A, Annapolis, MD 21401</i>								
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <i>Diana S. Park</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28040

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death Hour Minute AM/PM	
Roy Kenneth Estes		August 31, 2011			0546 M	
4a. Facility Name (if not institution, give street and number) Gilchrist		4b. City, Town, or Location of Death Columbia			4c. County of Death Howard	
5. Social Security Number 105-20-0544		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 27, 1929	9. Birthplace (State or Foreign Country) New York
Usual Residence of Decedent MD Howard		10a. State 10b. County 10c. City, Town or Location Ellicott City			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 11662 Foxspur Court		10f. Zip Code 21042			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1951-53			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Salesman			16b. Kind of Business Industry Retail	
17. Father's Name (First, Middle, Last) Irving L. Estes		18. Mother's Name (First, Middle, Maiden Surname) Lucy Hoefler				
19a. Informant's Name/Relationship (Type, Print) Phyllis Ann Estes/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11662 Foxspur Court Ellicott City, MD 21042				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Final Journey Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) MO1251			Date 09/02/11	20c. Location - City or Town, State Woodbine, MD
21. Signature of Funeral Service Licensee ► Beverly L. Heckrotte		22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death Weekly	
Sequentially list conditions, if any, leading to immediate cause. Enter in <b>Order</b> . Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  ESOPHAGEAL CANCER				
		b. Due to (or as a consequence of):				
		c. Due to (or as a consequence of):				
		d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier ► Kathryn Blackford CNP		29c. License number R047324			29d. Date signed (Month, Day, Year) AUGUST 31, 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHRYN BLACKFORD CNP 6336 CEDAR LANE COLUMBIA, MD 21044						
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Kathryn Blackford CNP				

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28041

1 - For State Registrar

## Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jean Henrietta Ferrell</i>							2. Date of Death Month Day Year <i>August 30th 2011</i>	3. Time of Death <i>19:10 p.m.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>			4b. City, Town, or Location of Death <i>Columbia</i>			4c. County of Death <i>Howard</i>			
Funeral Director	5. Social Security Number <i>214-28-7036</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>May 6, 1929</i>	9. Birthplace (State or Foreign Country) <i>W. Virginia</i>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Howard</i>				10c. City, Town or Location <i>Columbia</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>7070 Craddlerock Way Apt. 428</i>				10f. Zip Code <i>21045</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>2</i>		16b. Kind of Business Industry <i>Licensed Practical Nurse</i>			Health Care		
	17. Father's Name (First, Middle, Last) <i>unknown</i> Morton				18. Mother's Name (First, Middle, Maiden Surname) <i>unknown</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Denise Traill /Personal Rep.</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2517 Appaloosa Way; Finksburg, MD 21048</i>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>All Faiths Crematory &amp; Chapel</i>		Date <i>9/2/11</i>	20c. Location - City or Town, State <i>Manchester, MD</i>				
	21. Signature of Funeral Service licensee <i>Ronald J. Ferrell</i>		22. Name and Address of Facility <i>Eckhardt Funeral Chapel P.A.</i> <i>11605 Reisterstown Rd. Owings Mills, MD 21117</i>							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Hepatosplenomegaly</i>								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>End stage cardiomyopathy</i></p> <p>b. Due to (or as a consequence of): <i>Diabetes</i></p> <p>c. Due to (or as a consequence of): <i>Hypertension</i></p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>atrial fibrillation</i> <i>Asthma - Liver Cirrhosis Asci</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D50870</i>		29d. Date signed (Month, Day, Year) <i>August 30th 2011</i>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Suzan Abdool, MD 10910 Little Patuxent Parkway Suite 202 Columbia MD 21046</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Leanne J. Ferrell</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28042

1 - For State Registrar

Physician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death				
		<b>Alvin Wesley Farrell</b>				Month <b>08</b> Day <b>31</b> Year <b>2011</b>		Time <b>10:33 A.M.</b>				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death		4d. Inside City Limits				
<b>Gilchrist Hospice</b>		<b>Towson</b>				<b>Baltimore</b>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		
<b>217-48-5414</b>		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<b>51</b> Yrs.	Months	Days	Hours	Min.	<b>10 09 59</b>	<b>MD</b>			
Usual Residence of Decedent												
10a. State		10b. County		10c. City, Town or Location						10d. Inside City Limits		
<b>MD</b>		<b>NA</b>		<b>Baltimore</b>						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?						
<b>1911 Burnwood Road</b>		<b>21239</b>				<b>U.S.A.</b>						
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
<b>Elementary/Secondary (0-12)</b>		<b>College (1-4 or 5+)</b>			<b>Toll Collector</b>			<b>State of Maryland</b>				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)										
<b>Charles E. Farrell</b>		<b>Evelyn M. Yarborough</b>										
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
<b>Anthony Farrell-Brother</b>		<b>2 Retinue Court Apt T-1, Baltimore, Md 21207</b>										
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State					
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		<b>On-Site</b>			<b>9/3/2011</b>		<b>Baltimore, Md</b>					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility										
<i>Laura C. Patel</i>		<b>March F/H West</b> <b>4300 Wabash Ave, Baltimore, Md 21215</b>										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of):  <i>metastatic rectal cancer</i>				Approximate Interval Between Onset and Death <i>months</i>						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):  <i>metastatic rectal cancer</i>										
{		23d. Due to (or as a consequence of):  <i>metastatic rectal cancer</i>										
23e. Did tobacco use contribute to the cause of death?  <i>pathological left humerus fracture 2° to fall</i>		23f. Date of delivery Month Day Year										
1 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work?		28d. Describe how injury occurred				
<b>OS/23/2011</b>		<b>1033 A M</b>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>Fall</b>						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
<b>Home</b>		<b>Baltimore, Md 1911 Burnwood Rd</b>										
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Laura Patel</i>				29c. License number		29d. Date signed (Month, Day, Year)				
						<b>D0070635</b>		<b>8/31/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
<b>Laura Patel 6701 N Charles St Suite 4105 Baltimore, MD 21205</b>												
31. Date filed (Month, Day, Year)		32. Registrar's Signature										
<b>SEP 06 2011</b>		<i>Laura C. Patel</i>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician/  
Medical  
Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28043

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>George Louis Fountain</b>			2. Date of Death Month Day Year <b>08 28 2011</b>			3. Time of Death <b>01:52 M</b>		
4a. Facility Name (if not institution, give street and number) <b>Montgomery General Hospital</b>			4b. City, Town, or Location of Death <b>Olney</b>			4c. County of Death <b>Montgomery</b>		
5. Social Security Number <b>155-10-9270</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>05 20 16</b>	9. Birthplace (State or Foreign Country) <b>NJ</b>	
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>15002 Candover Court</b>			10f. Zip Code <b>20906</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Director of EEO at Fort Meade</b>		16b. Kind of Business Industry <b>Federal Government</b>				
17. Father's Name (First, Middle, Last) <b>Charles Wesley Fountain</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Essie Vincent</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Georgene Louise Fountain</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20319 Thunderhead Way, Germantown, Md 20874</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>On-Site</b>			Date <b>9/1/2011</b>	20c. Location - City or Town, State <b>Baltimore, Md</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore, Md 21215</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <b>years</b>					
a. Due to (or as a consequence of): <b>Atherosclerotic Cardiovascular Disease</b>								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D 0028429</b>		29d. Date signed (Month, Day, Year) <b>August 28, 2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Phyllis Nicholson, Montgomery General Hospital 18101 Prince Phillip Drive Olney</b>		32. Registrar's Signature 						
31. Date filed (Month, Day, Year) <b>SFP 06 2011</b>		32. Registrar's Signature 						

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28044

**1-** For  
State  
Registrar

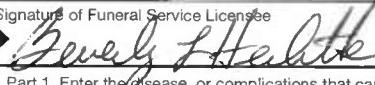
**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Patrick Carl Fischer</b>			2. Date of Death Month <b>August</b> Day <b>26</b> , Year <b>2011</b>			3. Time of Death <b>9:00 A M</b>	
4a. Facility Name (if not institution, give street and number) <b>Casey House</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>383-34-1114</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 3, 1935</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Gaithersburg</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>431 Fellowship Circle</b>			10f. Zip Code <b>20877</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor</b>			16b. Kind of Business Industry <b>Education</b>	
17. Father's Name (First, Middle, Last) <b>Carl Hahn Fischer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen Kirkpatrick</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charlotte Froese Fischer/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>431 Fellowship Circle Gaithersburg, MD 20877</b>				

To Be Completed by Physician/Medical Examiner

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>08/27/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
<p>a. <b>Gastric Carcinoma</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>R143201</b> 29d. Date signed (Month, Day, Year) <b>8/26/11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Debrah Miller CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

20

**State  
Registrar**

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28045

1 - For State Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Joseph Anthony Favazza</b>				2. Date of Death Month <b>September</b> Day <b>2</b> , Year <b>2011</b>	3. Time of Death 3:31 P M				
	4a. Facility Name (if not institution, give street and number) <b>1907 Corbridge Lane</b>				4b. City, Town, or Location of Death <b>Monkton</b>		4c. County of Death <b>Baltimore</b>			
<b>Funeral Director</b>	5. Social Security Number <b>220-86-9308</b>	6. Sex <input checked="" type="checkbox"/> X M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Sept 15, 1964</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b> 10b. County <b>Baltimore</b>				10c. City, Town or Location <b>Monkton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1907 Corbridge Lane</b>				10f. Zip Code <b>21111</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Technician</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Ruck Towson Funeral Home, Inc.</b>			16b. Kind of Business Industry <b>Computers</b>		
	17. Father's Name (First, Middle, Last) <b>Vincent N. Favazza</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maxine N. Feingold</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Vincent N. Favazza / Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1907 Corbridge Lane; Monkton, MD 21111</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>9/6/2011</b>	20c. Location - City or Town, State <b>Towson, MD</b>				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc.</b>		1050 York Road Towson, MD 21204					
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Carbon Monoxide Poisoning					
	a. Due to (or as a consequence of): <i>Suicide due to exhaust fumes</i>				Approximate Interval Between Onset and Death					
	b. _____ Due to (or as a consequence of):									
	c. _____ Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month <b>0</b> Day <b>0</b> Year <b>0</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>09/02/2011</b>	28b. Time of injury <b>1531P</b> M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>subject inhaled generator exhaust fumes</b>				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Monkton, MD 1907 Corbridge Lane</b>							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 		29c. License number <b>D18667</b>		29d. Date signed (Month, Day, Year) <b>September 3, 2011</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip M. Leach, MD</b>									
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For  
State  
Registrar

Reg. No.

2011 28046

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)  
**Mathias Fox**

2. Date of Death

Month **Aug 31** Day **31** Year **2011**

3. Time of Death

**11:28 AM**

4a. Facility Name (if not institution, give street and number)  
**228 Principio Road**

4b. City, Town, or Location of Death  
**Port Deposit**

4c. County of Death  
**Cecil**

5. Social Security Number  
**217-34-8560**

6. Sex  
 M  F

7. Age (In yrs. last birthday)  
**72** Yrs.

If Under 1 Year  
Months **0** Days **0** Hours **0** Min. **0**

8. Date of Birth  
(Month, Day, Year)  
**Mar 3, 1939**

9. Birthplace (State or Foreign  
Country)  
**Maryland**

Usual Residence of Decedent

10a. State  
**Md.**

10b. County  
**Cecil**

10c. City, Town or Location  
**Port Deposit**

10d. Inside City Limits  
 Yes  No

10e. Street and Number

**228 Principio Road**

10f. Zip Code

**21094-2008**

10g. Citizen of What Country?

**U.S.A.**

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
 Yes  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) **12th**

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

**Self-Employed**

16b. Kind of Business Industry

**Self-Employed**

17. Father's Name (First, Middle, Last)

**Marius Fox**

18. Mother's Name (First, Middle, Maiden Surname)

**Mary Papa**

19a. Informant's Name/Relationship (Type, Print)

**Vincent Fox / Son**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**228 Principio Road Port Deposit, Md. 21094**

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Holy Rosary Cem.**

20c. Month **September**

Day **6**

Year **2011** Location - City or Town, State  
**Baltimore, Maryland**

21. Signature of Funeral Service Licensee



22. Name and Address of Facility **Kaczorowski Funeral Home, PA**  
**1201 Dundalk Avenue Baltimore, Md. 21222**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

**Lung Cancer**

Approximate Interval Between Onset and Death

- a. Due to (as a consequence of):  
**Lung Cancer**
- b. Due to (as a consequence of):  
\_\_\_\_\_
- c. Due to (as a consequence of):  
\_\_\_\_\_
- d. Due to (as a consequence of):  
\_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Unknown  Other (specify) \_\_\_\_\_

23d. Date of delivery  
Month  Day  Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
 Yes  No  Probably  Unknown

25. Was case referred to medical examiner?  
 Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Son's home

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
M  Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

**D0057465**

29d. Date signed (Month, Day, Year)

**8/31/11**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**N S Rayapakar, M.D.**

**2835 Smith Av 5203**

**Baltimore MD 21209**

31. Date filed (Month, Day, Year)

**SEP 06 2011**

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

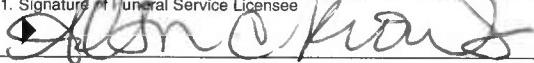
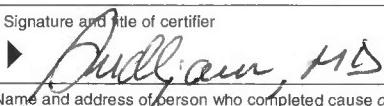
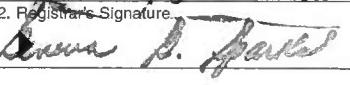
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28047

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HENRY T. GOSS</b>							2. Date of Death Month <b>08</b> Day <b>20</b> Year <b>2011</b>		3. Time of Death <b>8:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LORIEN BEL AIR</b>			4b. City, Town, or Location of Death <b>Loch Raven</b>			4c. County of Death <b>Harford</b>				
Funeral Director	5. Social Security Number <b>244-42-5759</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>78</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>May 14, 1933</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Harford</b>			10c. City, Town or Location <b>Bel Air</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>1307 Scottsdale Drive Apt.A</b>			10f. Zip Code <b>21015</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business/Industry <b>Department Store</b>				
	17. Father's Name (First, Middle, Last) <b>Henry Goss</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Ellis</b>							
	19a. Informant's Name/Relationship (Type. Print) <b>Gwen Brown/ Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>506 Inglewood Road Bel Air, MD 21015</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem'l Park</b>			Date <b>Aug 30, 2011</b>	20c. Location - City or Town, State <b>Glen Burnie, MD</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Ambrose Funeral Home, Inc.</b> <b>1328 Sulphur Spring Road Arbutus, MD 21227</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>PARKINSON'S DISEASE, END STAGE</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	b. _____ Due to (or as a consequence of):										
	c. _____ Due to (or as a consequence of):										
	d. _____										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, DYSLIPIDEMIA, GERD.</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 			29c. License number <b>D45344</b>			29d. Date signed (Month, Day, Year) <b>08/22/2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURESH DUTTANZAI MD 6225 UNION AVE, HAVRE DE GRACE, MD 21078</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28048

1 - For State Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Louvenia Gray</b>		2. Date of Death Month Day Year <b>September 1, 2011</b>		3. Time of Death 9:30p M
4a. Facility Name (if not institution, give street and number) <b>Lorien- Mt. Airy</b>		4b. City, Town, or Location of Death <b>Mt. Airy</b>		4c. County of Death <b>Carroll</b>
5. Social Security Number <b>223-26-4179</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>July 1 1924</b>
9. Birthplace (State or Foreign Country) <b>VA</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
10a. State <b>MD</b>		10b. County <b>Carroll</b>	10c. City, Town or Location <b>Mt. Airy</b>	
10e. Street and Number <b>705 Midway Avenue</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white</b>	
14. Race - American Indian, Black, White, etc. <b>Specify: white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>		16b. Kind of Business Industry <b>domestic</b>		
17. Father's Name (First, Middle, Last) <b>William Nathan</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lockie Louvenia Baldwin</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lisa Boggs (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13999 Old Blanco Rd., San Antonio, TX 78216</b>		
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springfield Cemetery</b>	Date <b>9-6-11</b>	20c. Location - City or Town, State <b>Sykesville, MD</b>
21. Signature of Funeral Service Licensee <b>Paige Haught Herbert</b>		22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>1 week</b>		
a. <b>Stroke/CVA</b> Due to (or as a consequence of): <b>ASCVD</b>				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>		
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <b>Tracie L. Ryberg, D.O.</b>		29c. License number <b>H0061206</b>		29d. Date signed (Month, Day, Year) <b>9/2/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tracie L. Ryberg, D.O. 688-C Poole Rd. Westminster, MD 21157</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Seneca J. Parker</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28049

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen May Goetz</b>						2. Date of Death Month Day Year <b>August 31, 2011</b>	3. Time of Death M <b>1450 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Long View Nursing Home</b>			4b. City, Town, or Location of Death <b>Manchester</b>			4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>219-12-0048</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent MD Baltimore		10a. State 10b. County 10c. City, Town or Location <b>Owings Mills</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>12209 Park Heights Ave.</b>			10f. Zip Code <b>21117</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Daniel Winfield Williams</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Effie Wetzel</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Bonnie Keeney / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1021 Green Hill Farm Rd. Reisterstown, MD 21136</b>			Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Finksburg, MD</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Evergreen Memorial Gardens</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Finksburg, MD</b>	
	21. Signature of Funeral Service Licensee <b>► Helen J. Keeney</b>		22. Name and Address of Facility <b>Eckhardt Funeral Chapel P.A.</b> <b>11605 Reisterstown Rd. Owings Mills, MD 21117</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Senile dementia</b>						Approximate Interval Between Onset and Death <b>years</b>	
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last							
	a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>►</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>►</b>		29c. License number <b>D37573</b>			29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sofia Zibell MD 2835 Smith Ave Baltimore MD 21209</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Sofia Zibell</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

certificate.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28050

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY K GARDNER</b>				2. Date of Death Month Day Year <b>August 31, 2011</b>	3. Time of Death <b>9:35 A M</b>
	4a. Facility Name (if not institution, give street and number) <b>Sanctuary at Holy Cross</b>		4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>223-68-0464</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b> </b>	8. Date of Birth (Month, Day, Year) <b>May 14, 1945</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Howard</b>				10c. City, Town or Location <b>Columbia</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>5370 Five Fingers Way</b>			10f. Zip Code <b>21045</b>	10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>African American</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Microbiologist</b>		16b. Kind of Business Industry <b>Research</b>	
	17. Father's Name (First, Middle, Last) <b>James Ammons Kidd</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Christian Alice Young</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>John E. Gardner</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5370 Five Fingers Way Columbia, MD 21045</b>		
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>09/06/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>GLIOBLASTOMA</b>					
	Approximate Interval Between Onset and Death					
	a. Due to (or as a consequence of): <b> </b>					
	b. Due to (or as a consequence of): <b> </b>					
	c. Due to (or as a consequence of): <b> </b>					
	d. Due to (or as a consequence of): <b> </b>					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURE DISORDER</b>					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier 					
	29c. License number <b>J 28595</b>					
	29d. Date signed (Month, Day, Year) <b>8/31/11</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TASNEEM LAKHANI, 2855 SMITH AVE, BALTIMORE MD 21208</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28051

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 08:35 M	
Muriel Gibson		08/21/2011			
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Seasons Hospice of Baltimore		Randallstown, MD		Baltimore	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 4/14/1927
215-24-9368					9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore			
10e. Street and Number 919 N. Belnord Ave.		10f. Zip Code 21205		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping		16b. Kind of Business Industry Spring Grove- MD State	
17. Father's Name (First, Middle, Last) William Gregory		18. Mother's Name (First, Middle, Maiden Surname) Charity Payne			
19a. Informant's Name/Relationship (Type, Print) Nina Hawkins- Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9500 Sidebrook Rd#107 Owings Mills, MD 21117			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		Date 8/29/2011	20c. Location - City or Town, State Owings Mills, MD
21. Signature of Funeral Service Licensee ► Brian McLean		22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular accident			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of):</p> <p>{</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Inpatient hospice			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29e. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier ► Dr. Betty Wang		29c. License number H64261		29d. Date signed (Month, Day, Year) 8/21/2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Betty Wang 6190 Georgetown Blvd., Ellicott City MD 21042		31. Date filed (Month, Day, Year) SEP 06 2011			
32. Registrar's Signature Jane J. Pace					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28052

1. For State  
Registrar**Physician/  
Medical Examiner**

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>Brian David Goodman</b>						2. Date of Death Month Day Year <b>September 4, 2011</b>	3. Time of Death 0404 hrs
4a. Facility Name (if not institution, give street and number) <b>Upper Chesapeake Medical Center</b>			4b. City, Town, or Location of Death <b>Bel Air</b>			4c. County of Death <b>Harford</b>	
5. Social Security Number <b>217-78-5216</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b>	Yrs. Months Days	If Under 1 Year Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>May 21, 1967</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	

**Funeral Director**

**To Be Completed by Funeral Director**  
 Baltimore, MD 21215-0036  
 Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>8004 Delhaven Road 8004 Del Haven Road</b>		10f. Zip Code <b>21222</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry <b>Warehouse Clerk-Driver</b>	
17. Father's Name (First, Middle, Last) <b>George H. Goodman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy Teague</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Nancy Heffner/ Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3820 Southern Avenue Baltimore Maryland 21206</b>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>[Signature]</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>	Date <b>9/7/11</b>	20c. Location - City or Town, State <b>Towson Maryland</b>
21. Signature of Funeral Service Licensee <i>[Signature]</i>	22. Name and Address of Facility <b>Leopard J. Ruck, Inc. 5305 Hartford Road Baltimore Maryland 21214</b>		

**Physician /Medical Examiner**

**To Be Completed by Physician/Medical Examiner**  
 Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. _____ c. _____ d. _____			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED 10e, 23a, 27, per me, g919 9-8-11 sm			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>O.C.M.E.</b>	
29b. Signature and title of certifier <i>[Signature]</i>		29d. Date signed (Month, Day, Year) <b>September 4, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) <b>Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>			
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <i>[Signature]</i>	

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28053

Physician/ Medical Examiner		<b>1. For State Registrar</b> 1. Decedent's Name (First, Middle, Last) <b>Jerome Keith Golphin</b>										<b>2. Date of Death</b> Month Day Year <b>August 22, 2011</b>			<b>3. Time of Death</b> 1132 hrs				
Funeral Director		<b>4a. Facility Name (if not institution, give street and number)</b> <b>200 Block of Mt. Holly Street</b>					<b>4b. City, Town, or Location of Death</b> <b>Baltimore</b>			<b>4c. County of Death</b> <b>N/A</b>									
To Be Completed by Funeral Director		<b>5. Social Security Number</b> <b>219-31-0319</b>		<b>6. Sex</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		<b>7. Age (In yrs. last birthday)</b> <b>25</b> Yrs.			<b>If Under 1 Year</b> Months Days Hours Min.		<b>8. Date of Birth (MM/DD/YYYY)</b> <b>12/02/1985</b>		<b>9. Birthplace (State or Foreign Country)</b> <b>MD</b>						
To Be Completed by Physician/Medical Examiner		<b>10a. State</b> <b>MD</b>		<b>10b. County</b> <b>N/A</b>		<b>10c. City, Town or Location</b> <b>Baltimore</b>			<b>10d. Inside City Limits</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner		<b>10e. Street and Number</b> <b>213 Mt Holly St.</b>					<b>10f. Zip Code</b> <b>21229</b>					<b>10g. Citizen of What Country?</b> <b>U.S.A.</b>							
Baltimore, MD 21215-0036		<b>11. Marital Status</b> 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		<b>12. Was Decedent Ever in U.S. Armed Forces?</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>			<b>13. Was Decedent of Hispanic Origin? (Specify Yes or No)</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			<b>14. Race - American Indian, Black, White, etc.</b> Specify: <b>Black</b>									
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>15. Decedent's Education (Specify only highest grade completed)</b> Elementary/Secondary (0-12) <b>12th Grade</b>					<b>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)</b> <b>N/A</b>					<b>16b. Kind of Business/Industry</b> <b>N/A</b>							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		<b>17. Father's Name (First, Middle, Last)</b> <b>Anthony Golphin</b>					<b>18. Mother's Name (First, Middle, Maiden Surname)</b> <b>Robin Scott</b>												
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.		<b>19a. Informant's Name/Relationship (Type, Print)</b> <b>Robin Scott (mother)</b>					<b>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)</b> <b>213 Mt Holly St., Baltimore, MD 21229</b>												
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>20a. Method of Disposition</b> 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		<b>20b. Place of Disposition (Name of cemetery, crematory or other place)</b> <b>Mt. Zion Cem.</b>			<b>Date</b> <b>08/27/11</b>		<b>20c. Location - City or Town, State</b> <b>Baltimore, MD</b>										
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>21. Signature of Funeral Service Licensee</b> 					<b>22. Name and Address of Facility</b> <b>Joseph H. Brown Jr. Funeral Home PA</b> <b>2140 N. Fulton Ave., Baltimore, MD 21217</b>												
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</b> <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>a. Multiple Gunshot Wounds</b> Due to (or as a consequence of):										<b>Approximate Interval Between Onset and Death</b>							
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>b.</b> Due to (or as a consequence of):																	
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>c.</b> Due to (or as a consequence of):																	
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>d.</b>																	
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED															
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>IF FEMALE:</b>		<b>23c. If yes, outcome of pregnancy</b>			<b>23d. Date of delivery</b>												
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			Month Day Year												
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b>										<b>23e. Did tobacco use contribute to the cause of death?</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>24a. Was an autopsy performed?</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										<b>24b. Were autopsy findings available prior to completion of cause of death?</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>25. Was case referred to medical examiner?</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>26. Place of Death (Check only one)</b> Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene															
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>27. Manner of Death</b>		<b>28a. Date of Injury (Month, Day, Year)</b> <b>Aug 22, 2011</b>		<b>28b. Time of Injury</b> <b>1118 hrs</b>		<b>28c. Injury at Work?</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			<b>28d. Describe how injury occurred</b> <b>Subject shot</b>								
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input checked="" type="checkbox"/> Homicide		<b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>Front Yard</b>		<b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> <b>200 Block of Mt. Holly Street, Baltimore, MD</b>													
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)</b> <b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>																	
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>29b. Signature and title of certifier</b> 										<b>29c. License number</b> <b>O.C.M.E.</b>			<b>29d. Date signed (Month, Day, Year)</b> <b>August 23, 2011</b>				
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>30. Name and address of person who completed cause of death (Item 23a)</b> <b>Laron Locke, MD - Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>																	
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<b>31. Date filed (Month, Day, Year)</b> <b>SEP 06 2011</b>		<b>32. Registrar's Signature</b> 															

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28054

Reg. No.

1- For State Registrar		Decedent's Name (First, Middle, Last) <b>Gilbert Gray</b>							2. Date of Death Month Day Year <b>Aug 26 2011</b>		3. Time of Death Hour AM <b>8:30 A M</b>						
Physician/ Medical Examiner		4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>Randallstown</b>				4c. County of Death <b>Baltimore</b>							
Funeral Director		5. Social Security Number <b>217-56-9356</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month Day Year) <b>12/25/1950</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
To Be Completed by Funeral Director		10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		10e. Street and Number <b>400 Seagull Ave</b>				10f. Zip Code <b>21225</b>				10g. Citizen of What Country? <b>USA</b>							
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>				16b. Kind of Business/Industry <b>Disabled</b>							
		17. Father's Name (First, Middle, Last) <b>Gilbert Gray Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bernice Brown</b>											
		19a. Informant's Name/Relationship (Type, Print) <b>Pamela Melvin Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5306 Remmell Ave Baltimore MD 21206</b>											
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crem</b>				Date <b>8/30/11</b>		20c. Location - City or Town, State <b>Glen Burnie MD</b>							
		21. Signature of Funeral Service Licensee <b>Thomas Allen</b>		22. Name and Address of Facility <b>Simplicity Crem &amp; Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD</b>													
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cancer, Pancreas</b> Approximate Interval Between Onset and Death															
		a. Due to (or as a consequence of): <b>Cancer, Pancreas</b>															
		b. Due to (or as a consequence of):															
		c. Due to (or as a consequence of):															
		d. Due to (or as a consequence of):															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year									
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Hospital				27. Manner of Death <b>Natural</b> <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>Aug 26 2011</b>		28b. Time of injury <b>M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>At home</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Glen Burnie MD 21206</b>													
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>015872</b>		29d. Date signed (Month, Day, Year) <b>Aug 26 2011</b>											
		29b. Signature and title of certifier <b>John Doe MD</b>		29c. License number <b>015872</b>		29d. Date signed (Month, Day, Year) <b>Aug 26 2011</b>											
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Doe MD 6934 Ringling Blvd Glen Burnie MD 21206</b>															
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>[Signature]</b>													

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28055

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: It is law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 shall be detached for use as the burial-transit once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month September Day First Year 2011		3. Time of Death 7:50 AM
James D Govans				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Mercy Medical center				
5. Social Security Number 217-66-2162		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days Hours Min.
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore
				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 408 N. Curley St.		10f. Zip Code 21224		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
				14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Laborer		16b. Kind of Business Industry Construction
17. Father's Name (First, Middle, Last) Charles Govans		18. Mother's Name (First, Middle, Maiden Surname) Ruth Robinson		
19a. Informant's Name/Relationship (Type, Print) Nadine Payne - friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 N. Curley St. Baltimore, Maryland		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 9/8/11
21. Signature of Funeral Service Licensee Kevin Parker		22. Name and Address of Facility Porter Funeral Home P.A. 21229 3512 Frederick Ave. Baltimore, Maryland		20c. Location - City or Town, State Dundalk, Maryland
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		(Approximate Interval Between Onset and Death)		
a. Due to (or as a consequence of): Infective endocarditis				
b. Due to (or as a consequence of): Intravenous drug use		10 years		
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis Spontaneous bacterial peritonitis		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Owen G. Debony MD		29c. License number 00070648		29d. Date signed (Month, Day, Year) September 1, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owen G. Debony, MD				
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Owen J. Parker		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28056

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

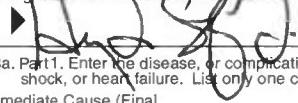
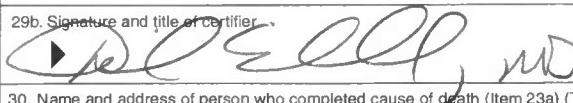
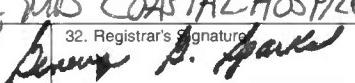
To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Phyllis Hyde</b>			2. Date of Death Month Day Year <b>September 1, 2011</b>				3. Time of Death 9:08A M				
4a. Facility Name (If not institution, give street and number) <b>6510 Cabin Ridge Road</b>			4b. City, Town, or Location of Death <b>Hurlock</b>				4c. County of Death <b>Dorchester</b>				
5. Social Security Number <b>212-36-4093</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>March 5, 1939</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent <b>Maryland Dorchester</b>			10a. State <b>Maryland</b> 10b. County <b>Dorchester</b> 10c. City, Town or Location <b>Hurlock</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>6510 Cabin Ridge Road</b>			10f. Zip Code <b>21643</b>				10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Homemaker</b>			16b. Kind of Business/Industry <b>Household</b>					
17. Father's Name (First, Middle, Last) <b>Miles Kennedy</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Bosley</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Robert J. Jyde, Sr. - Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6510 Cabin Ridge Rd., Hurlock, MD 21643</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Glen Haven Cemetery Sept. 7, 2011</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery Sept. 7, 2011</b>			Date <b>Sept. 7, 2011</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>			
21. Signature of Funeral Service License 			22. Name and Address of Facility <b>Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>Chronic Obstructive Lung Disease</b>								Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): <b>Chronic Obstructive Lung Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) <b>Unknown</b>						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier 		29c. License number <b>D26278</b>						29d. Date signed (Month, Day, Year) <b>9-1-11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID COEALLY, MD COASTAL HOSPICE PO BOX 1733 SALISBURY, MD 21802</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 									

within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 30, per DVR, g919 9-6-11 sm

State of Maryland / Department of Health and Mental Hygiene 2011 28057

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last) <i>Carlton Holland</i>		2. Date of Death Month Day Year <i>Aug 30 2011</i>		3. Time of Death M	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <i>Howard County General</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
Funeral Director		5. Social Security Number <i>215-62-4893</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>55 Yrs.</i>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) <i>April 21, 1956</i>	9. Birthplace (State or Foreign Country) <i>MD</i>
To Be Completed by Funeral Director		10a. State <i>MD</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Jessup</i>	
		10e. Street and Number <i>8117 Lincoln Dr</i>		10f. Zip Code <i>20794</i>		10g. Citizen of What Country? <i>USA</i>	
Physician/ Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk K</i>		16b. Kind of Business Industry <i>Grocery</i>	
		17. Father's Name (First, Middle, Last) <i>Charles Holland</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mabel Thomas</i>			
Physician/ Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <i>Patricia Holland</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18117 Lincoln Dr, Jessup, MD 20794</i>			
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Charleston Funeral</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadowridge</i>		Date <i>9/3/2011</i>	20c. Location - City or Town, State <i>Eldridge, MD</i>
		21. Signature of Funeral Service License <i>Charleston Funeral</i>		22. Name and Address of Facility <i>Howell Funeral Home</i>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pancreatitis</i>	
Physician/ Medical Examiner						Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner							
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
		27. Manner of death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>00072376</i>		29d. Date signed (Month, Day, Year) <i>Aug 31, 2011</i>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Charisse Sabath 5755 Cedar Lane Columbia, MD, 21044</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Charisse J. Sabath</i>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28058  
Reg. No.

1 - For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		John Heath		2. Date of Death		Month August 30 Year 2011		3. Time of Death	
4a. Facility Name (if not institution, give street and number)		2614 Greenmont Ave		4b. City, Town, or Location of Death		Baltimore		4c. County of Death	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
212-04-1106		<input checked="" type="checkbox"/> M	81 Yrs.			May 29, 1930	MD		
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits	
MD	N/A	Baltimore						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?					
2614 Greenmont Ave		21218		USA					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.			
unk		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: Black			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry					
Elementary/Secondary (0-12) unk		College (14 or 5+)		unk					
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
unk				unk					

19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Arthur Drager-Guardian		10 N Calvert St, Suite 620, Baltimore, MD	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Mt Carmel	9/1/2011
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	
Frank Howell Sr		Howell Funeral Home 4600 Liberty Heights Ave, Balto. MD 21207	

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)			
{			
a. coronary artery disease Due to (or as a consequence of):			
b. atherosclerosis Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			

IF FEMALE:		23c. If yes, outcome of pregnancy		23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?		<input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	Month Day Year		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?	
Systemic lupus erythematosis		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	

25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	

27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier		1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
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29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
Jamal McKaskie		00038046	9/1/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Jamal McKaskie 1000 Cathedral Street Baltimore, MD 21201	
31. Date filed (Month, Day, Year)	32. Registrar's Signature
SEP 06 2011	James J. Parker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28059

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Elizabeth Henderson

2. Date of Death

Month

Day

Year

August 31, 2011

3. Time of Death

0703 hrs

Physician/  
Medical ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. For State Registrar		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
		Elizabeth Henderson				Month Day Year		0703 hrs	
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
		Baltimore Washington Medical Center		Glen Burnie		Anne Arundel			
5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year		8. Date of Birth (MM/DD/YYYY)	
223-49-6125		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		35 Yrs.		Months Days Hours Min.		Feb. 27, 1976	
9. Birthplace (State or Foreign Country)		10. Usual Residence of Decedent		10a. State		10b. County		10d. Inside City Limits	
Virginia		10e. Street and Number		Maryland		Anne Arundel		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		White			
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		If Yes, Give Year or Dates:							
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry					
Elementary/Secondary (0-12)		College (1-4 or 5+)		Homemaker		Own Home			
12		+2							
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
James D. Sledd		Rebecca Mabe							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Timothy A. Henderson, Jr./Spouse		1224 Guilford Rd., Glen Burnie, Maryland 21060							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Sherwood Memorial Park		9/6/2011		Salem, Virginia			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:									
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		AMBROSE FUNERAL HOME, INC.					
Patricia M. Blakely		1328 Sulphur Spring Rd., Arbutus, Maryland 21227							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death?					
				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
Immediate Cause (Final disease or condition resulting in death)		a. Quetiapine Intoxication							
		Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b.							
		Due to (or as a consequence of):							
c.		Due to (or as a consequence of):							
d.		Due to (or as a consequence of):							
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g921 11-18-11 sm							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy		23d. Date of delivery					
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy		Month Day Year					
4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)		9 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner?		26. Place of Death (Check only one)		23e. Did tobacco use contribute to the cause of death?					
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		fd 8-31-11		fd 6:00 am		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		unknown	
2 <input type="checkbox"/> Accident		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined		residence							
4 <input type="checkbox"/> Homicide									
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)			
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		Theodore M. King, Jr., M.D.		O.C.M.E. OCME		September 1, 2011			
30. Name and address of person who completed cause of death (Item 23a)		Theodore M. King, Jr., MD. Assistant Medical Examiner		900 W. Baltimore Street, Baltimore, MD 21223					
31. Date filed (Month, Day, Year)		32. Registrar's Signature							
SEP 06 2011		Suzanne L. Parker							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28060

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last) <b>Gerald Horton</b>						2. Date of Death Month <b>9</b> Day <b>1</b> Year <b>2011</b>		3. Time of Death <b>5:20pm</b>					
		4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death					
Funeral Director		5. Social Security Number <b>218-48-2641</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		If Under 1 Year Months      Days      Hours      Min.		8. Date of Birth (Month, Day, Year) <b>7-10-1948</b>					
To Be Completed by Funeral Director		9. Usual Residence of Decedent <b>MD</b>		10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
		10e. Street and Number <b>1 W. Conway Street</b>		10f. Zip Code <b>21201</b>				10g. Citizen of What Country? <b>USA</b>							
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>							
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dental Technician</b>		16b. Kind of Business/Industry <b>Health</b>									
		17. Father's Name (First, Middle, Last) <b>Edward Horton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Cornish</b>											
		19a. Informant's Name/Relationship (Type, Print) <b>Wanda Laverne Johnson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6208 The Alameda, Baltimore, MD 21239</b>											
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Arbutus Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Cemetery</b>		Date <b>9-9-2011</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>							
		21. Signature of Funeral Service Licensee <b>VAUGHN GREENE FUNERAL SERVICES</b>		22. Name and address of Facility <b>4905 York Rd. Baltimore, MD 21212</b>											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute Leukemia</b>		23b. Approximate Interval Between Onset and Death											
		a. Due to (or as a consequence of): <b>Acute Leukemia</b>													
		b. Due to (or as a consequence of): <b></b>													
		c. Due to (or as a consequence of): <b></b>													
		d. Due to (or as a consequence of): <b></b>													
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month      Day      Year									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b> <b>Intracranial bleed</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b></b>		28b. Time of injury <b>M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b></b>		28b. Time of injury <b>M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DOOT7287</b>		29d. Date signed (Month, Day, Year) <b>9-2-11</b>									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shafeen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>James J. Gable</b>									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28061

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 2a is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		DORIS L HARRIS		Month	Day	Year	
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		7 SLADE AVENUE #203		BALTIMORE		BALTIMORE	
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth
		171-28-5674	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> XX	97 Yrs.	Months	Days	Month Day Year
		9. Birthplace (State or Foreign Country)		10. Inside City Limits		JULY 24, 1914 MD	
		10a. State		10b. County		10c. City, Town or Location	
		MD		BALTIMORE		BALTIMORE	
		10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
		7 SLADE AVENUE #203		21208		USA	
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry	
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) SALESPERSON		RETAIL	
		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
		ABRAHAM HANKIN		BESSIE GORFLICK			
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
		BARRY LEVER/SON		3206 WOODVALLEY DRIVE, BALTIMORE, MD 21208			
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory, or other place)		Date	20c. Location - City or Town, State
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		KESHER ISRAEL CONGREGATION CEM.		09/04/2011	HARRISBURG, PA
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKEVILLE, MD 21208	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
		Immediate Cause (Final disease or condition resulting in death)					
		a. Advanced Dementia					
		Due to (or as a consequence of):					
		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
		Approximate Interval Between Onset and Death 3 months					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		26. Place of Death (Check only one)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined					
		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier 					
		29c. License number 057426					
		29d. Date signed (Month, Day, Year) August 31, 2011					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot Rothchild : 4000 Old Court Rd., Potomac, MD					
		31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend items 23a, 25 per doc 919 9-6-11 vt

State of Maryland 7 Department of Health and Mental Hygiene

2011 28062

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

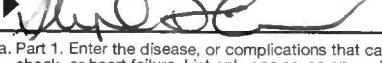
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Hallameyer, Christine  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Christine B. Hallameyer		08 18 2011		1230 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Citizen's Nursing Home		Havre de Grace		Hartford
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) March 9, 1921
213-09-4654				9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State MD	10b. County Baltimore	10c. City, Town or Location Perry Hall		
10e. Street and Number 9308 Summit View Way		10f. Zip Code 21128		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business Industry Own Home	
17. Father's Name (First, Middle, Last) George Becker			18. Mother's Name (First, Middle, Maiden Surname) Christina Heaton	
19a. Informant's Name/Relationship (Type, Print) James E. Hallameyer (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9308 Summit View Way, Perry Hall, MD 21128		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 9		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory	Date 08/23/11	20c. Location - City or Town, State Glen Burnie, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Home, Inc.	610 W. MacPhail Road, Bel Air, MD 21014	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Acute Myocardial Infarction <i>Failure to thrive</i>		
		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
{		b. Due to (or as a consequence of):		
{		c. Due to (or as a consequence of):		
{		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D42800		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 8/18/11		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas A. Browne MD, 251 Davis Lane, Hillside, NJ, 07241				
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature 		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 25 per me, g918,08/31/2011dhb Certificate of Death

2011 28063

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>G. Anne L. Hamilton</b>										2. Date of Death Month Day Year <b>AUGUST 3, 2011</b>		3. Time of Death 17:13pM					
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>				4c. County of Death <b>BALTIMORE</b>									
To Be Completed by Funeral Director		5. Social Security Number <b>214-38-0221</b>		6. Sex <b>M</b>		7. Age (In yrs. last birthday) <b>71 Yrs.</b>		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) <b>May 28, 1940</b>		9. Birthplace (State or Foreign Country) <b>PA</b>							
To Be Completed by Physician/Medical Examiner		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lutherville</b>						10d. Inside City Limits <b>Yes</b>							
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>315 W. Seminary Ave.</b>				10f. Zip Code <b>21093</b>				10g. Citizen of What Country? <b>USA</b>									
To Be Completed by Physician/Medical Examiner		11. Marital Status <b>Widowed</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>Yes</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <b>No</b>						14. Race - American Indian, Black, White, etc. <b>White</b>							
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>5+</b> <b>English Teacher</b>				16b. Kind of Business Industry <b>Baltimore Education, County</b>									
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>James L. Llewellyn</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude C. Carter</b>											
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Geoffrey Carter/Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1109 Southampton Road Bel Air, MD 21014</b>													
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <b>Burial</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>				Date <b>August 9, 2011</b>		20c. Location - City or Town, State <b>Timonium, MD</b>							
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Worker <b>Michael J. Flagle</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc.</b> <b>10 W. Padonia Road Timonium, MD 21093</b>													
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death  <i>Intracranial hemorrhage</i>					
To Be Completed by Physician/Medical Examiner		a. Due to (or as a consequence of):  <i>Intracranial hemorrhage</i>																	
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):  <i>Intracranial hemorrhage</i>																	
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):  <i>Intracranial hemorrhage</i>																	
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>Yes</b>		23c. If yes, outcome of pregnancy <b>Live Birth</b>				23d. Date of delivery Month Day Year											
To Be Completed by Physician/Medical Examiner		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown															
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23e. Did tobacco use contribute to the cause of death? <b>No</b>					
To Be Completed by Physician/Medical Examiner														1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <b>Yes</b>		26. Place of Death (Check only one) <b>Hospital</b>				27. Place of Death <b>Natural</b>				28a. Date of injury (Month, Day, Year) <b>1 Inpatient</b>		28b. Time of injury <b>M</b>		28c. Injury at work? <b>Yes</b>		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner		2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6535 N. Charles, N. Pavilion Suite 550, Towson, MD 21204</b>			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <b>Certifying Physician</b>		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
To Be Completed by Physician/Medical Examiner		2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner		On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <b>Mark Gosnell MD</b>		29c. License number <b>DC058082</b>				29d. Date signed (Month, Day, Year) <b>8/4/11</b>											
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark Gosnell 6535 N. Charles, N. Pavilion Suite 550, Towson, MD 21204</b>																	
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>		32. Registrar's Signature <b>Suzanne S. Parker</b>															

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28064

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

6:30 A.M.  
**Baltimore, Maryland 21215-0036**  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

		1. Decedent's Name (First, Middle, Last) <b>HELEN L. HUBER</b>		2. Date of Death Month <b>AUGUST</b> Day <b>29</b> , Year <b>2011</b>		3. Time of Death <b>6:30 A.M.</b>	
		4a. Facility Name (if not institution, give street and number) <b>Stella Maris</b>		4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
		5. Social Security Number <b>219-12-6512</b>	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month Day Year) <b>March 4, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Nottingham</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>23 Chesthill Ct.</b>		10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th. Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Worker</b>		16b. Kind of Business Industry <b>Cup Company</b>	
		17. Father's Name (First, Middle, Last) <b>Louis Goldsmith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lelia White</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Raymond St. Clair/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23 Chesthill Ct., Baltimore MD 21236</b>			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		Date <b>09/01/2011</b>	20c. Location - City or Town, State <b>Baltimore MD</b>
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Charles S. Zeiler &amp; Son, Inc. 6224 Eastern Avenue Baltimore MD 21224</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Bilateral Pneumonia</b> Due to (or as a consequence of): <b>Weeks</b> Approximate Interval Between Onset and Death					
		b. _____ Due to (or as a consequence of): _____					
		c. _____ Due to (or as a consequence of): _____					
		d. _____					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier 		29c. License number <b>DS2740</b>		29d. Date signed (Month, Day, Year) <b>August 29th 2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093</b>					
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature 				

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e-g, per FHF, G919, 9/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28065

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	Josephine - Hudson			2. Date of Death			
			Month	Day	Year	3. Time of Death	
			8	29	2011	22 15 PM	
4a. Facility Name (if not institution, give street and number)	FRANKLIN SQUARE HOSPITAL			4b. City, Town, or Location of Death	Rosedale		
5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
217-03-3560	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	94	Yrs.	Months	Days	Hours	Min. June 19, 1917 Maryland
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits		
MD	Baltimore	Parkville			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
8810 Walther Blvd. #1125			21234			USA	

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry
Elementary/Seconday (0-12) 12	College (1-4 or 5+)	Secretary	Army
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
Carmello		Panzarella Vincenzina Federico	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
William Hudson-husband		8810 Walther Blvd., #1125, Parkville, MD 21234	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Dulaney Valley	9/3/11
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	Ruck Towson Funeral Home, Inc.
William G. Dau		1050 York Rd., Towson, MD 21204	

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)			
a. Congestive Heart Failure Due to (or as a consequence of):			
b. Fluid overload Due to (or as a consequence of):			
c. colistridium difficile infection Due to (or as a consequence of):			
d. streptococcus infection			
IF FEMALE:			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
history of CHF, ascites, atrial fibrillation chronic renal insufficiency		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 (Check 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 only one) 3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RES0000

8-29-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR AZRA I SHAIKH 9000 FRANKLIN SQUARE DR BALTO MD 21237

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28066

1-  
For  
State  
Registrar

<b>Physician/ Medical Examiner</b>		1. Decedent's Name (First, Middle, Last) <b>Don Y. Hibino</b>								2. Date of Death Month Day Year <b>August 25, 2011</b>		3. Time of Death 4:50 P M					
<b>Funeral Director</b>		4a. Facility Name (if not institution, give street and number) <b>Angels Garden Assisted Living</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>							
<b>To Be Completed by Funeral Director</b>		5. Social Security Number <b>567-24-1039</b>		6. Sex <b>1 X M 2 <input type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>91</b> Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) <b>Aug 27, 1919</b>		9. Birthplace (State or Foreign Country) <b>California</b>					
		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>							
		10e. Street and Number <b>5051 Waukesha Road</b>				10f. Zip Code <b>20816</b>				10g. Citizen of What Country? <b>USA</b>							
		11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 X Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 X No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>Specify: Asian</b>							
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 5+ Owner</b>				16b. Kind of Business/Industry <b>Supplies Retail Construction</b>							
		17. Father's Name (First, Middle, Last) <b>Junzo Hibino</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ito Kawakami</b>											
		19a. Informant's Name/Relationship (Type, Print) <b>Diane Hibino/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5051 Waukesha Road Bethesda, MD 20816</b>											
		20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Final Journey Crematory</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>09/01/11</b>				Date <b>Woodbine, MD</b>							
		21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte MO1251</b>				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>								Approximate Interval Between Onset and Death							
		<p>a. <b>Failure to Thrive</b> Due to (or as a consequence of):</p> <p>b. <b>Dementia</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>				23d. Date of delivery Month Day Year									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, Chronic Kidney Disease</b>								23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 X Unknown</b>							
										24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 X No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			
		25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>assisted living</b>				26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 X Other (Specify)									
		27. Manner of Death <b>1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>						29a. License number <b>D38459</b>				29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>					
		29b. Signature and title of certifier <b>Nakul Goyal, M.D.</b>															
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nakul Goyal, M.D. 3801 International Dr. #211 Silver Spring, MD 20906</b>															
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Anna P. Parker</b>													

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28067

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

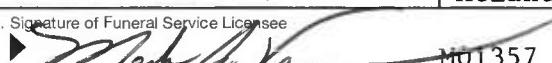
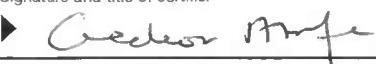
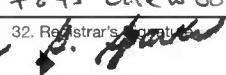
Humphrey Helen  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>Helen G. Humphrey</b>							2. Date of Death Month Day Year <b>September 2 2011</b>	3. Time of Death <b>6:13 p m</b>
4a. Facility Name (if not institution, give street and number) <b>Baltimore Washington Medical Center</b>							4b. City, Town, or Location of Death <b>Glen Burnie</b>	4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>212-22-5140</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06/16/1925</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Linthicum</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>110 S. Midfield Road</b>				10f. Zip Code <b>21090</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry <b>Homemaker</b>			Own Home	
17. Father's Name (First, Middle, Last) <b>Ferris Griffith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Roberta</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Robert L. Humphrey / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>110 S. Midfield Road, Linthicum, MD 21090</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>		Date <b>9/5/2011</b>	20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>1 2nd Ave, SW Glen Burnie, MD</b> <b>Singleton Funeral &amp; Cremation Services, P.A.</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>END stage Parkinson's Disease</b>						
b. Due to (or as a consequence of): <b>Dementia</b>								
c. Due to (or as a consequence of): d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>D0062148</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2<sup>nd</sup> 2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CEDRIC ATNACH 7845 Oatwood Rd #105, Glen Burnie MD 21061</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's signature 						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28068

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last) <b>JOHN HAVER</b>						2. Date of Death Month <b>08</b> Day <b>31</b> Year <b>11</b>		3. Time of Death <b>1403 M</b>	
		4a. Facility Name (if not institution, give street and number) <b>SHOCK TRAUMA</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director		5. Social Security Number <b>213-72-7592</b>	6. Sex <b>XX M</b> <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month Day Year) <b>11/6/1958</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>						10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <b>XX</b> No
		10e. Street and Number <b>12 Gilmore Street</b>			10f. Zip Code <b>21061</b>			10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <b>XX</b> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <b>XX</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Mason</b>		16b. Kind of Business Industry <b>Construction</b>					
		17. Father's Name (First, Middle, Last) <b>John R. Hafer, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Marie Vogel</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Dawn Hafer / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 Gilmore Street Glen Burnie, MD 21061</b>						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>LOUDEN PARK CEMETERY</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Louden Park Cemetery</b>		Date <b>9/6/2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>			
		21. Signature of Funeral Service Licensee <b>CATHY HAVER MO1594</b>			22. Name and Address of Facility <b>SINGLETON FUNERAL &amp; CREMATION SERVICES, PA 1 2nd Ave SW Glen Burnie, MD 21061</b>						
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b>						Approximate Interval Between Onset and Death <b>38 DAYS</b>			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CELLULITIS</b>						<b>38 DAYS</b>			
		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) <b>9 Unknown</b>						23d. Date of delivery Month Day Year			
		23e. Did tobacco use contribute to the cause of death? <b>DIABETES, HYPERTENSION</b>						1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		23f. Were autopsy findings available prior to completion of cause of death? <b>HEMOCHROMATOSIS</b>						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>DROPPED BOX ON LEG</b>			
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						28a. Date of injury (Month, Day, Year) <b>07/24/11</b> 28b. Time of injury <b>UNK</b> M 28c. Injury at work? <b>1 Yes 2 No</b> 28d. Describe how injury occurred <b>AT SEA</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ON CRAB BOAT</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29d. Date signed (Month, Day, Year) <b>08/31/11</b>			
		29b. Signature and title of certifier <b>CATHERINE NELSON</b>						29c. License number <b>RES001</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CATHERINE NELSON 12 GREENE ST, BALTIMORE MD 21201</b>						31. Date filed (Month, Day, Year) <b>SEP 06 2011</b> 32. Registrar's Signature <b>J. J. Hafer</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

10 sm  
State  
Registrar

Kennard Hailey

11-06390  
UNK UNK

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28069

## 1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kennard William Hailey</b>						2. Date of Death Month Day Year August 25, 2011	3. Time of Death 0059 hrs
--------------------------------	---	--	--	--	--	--	---	------------------------------

4a. Facility Name (if not institution, give street and number) <b>Johns Hopkins Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>	
---	--	--	--	--	--	-----------------------------------	--

5. Social Security Number <b>219-06-0791</b>		6. Sex <b>1 [X] M 2 [ ] F</b>	7. Age (In yrs. last birthday) <b>26</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) <b>10/26/1984</b>	9. Birthplace (State or Foreign Country) <b>USA</b>
---	--	----------------------------------	---	---------------------------	--------------------------	--	--

10a. State <b>PA</b>		10b. County <b>N/A</b>	10c. City, Town or Location <b>Philadelphia</b>				10d. Inside City Limits <b>1 [ ] Yes 2 [X] No</b>
-------------------------	--	---------------------------	--	--	--	--	--

10e. Street and Number <b>5224 Wayne Ave.</b>			10f. Zip Code <b>19144</b>			10g. Citizen of What Country? <b>USA</b>	
--	--	--	-------------------------------	--	--	---	--

11. Marital Status <b>1 [X] Never Married 2 [ ] Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 [ ] Yes 2 [X] No</b> If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 [ ] Yes 2 [X] No</b> specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
--	---	---	--	--	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Various Jobs</b>
---	--	---	--	--	---

17. Father's Name (First, Middle, Last) <b>Kennard Hailey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Daphne Henson</b>				
--	--	--	---	--	--	--	--

19a. Informant's Name/Relationship (Type, Print) <b>Grand Loretta Williams- Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4921 Goodnow Road Apt. G Baltimore, MD 21206</b>				
---	--	--	--	--	--	--

20a. Method of Disposition <b>1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State</b> 4 [ ] Donation 5 [ ] Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>			Date <b>9/1/2011</b>	20c. Location - City or Town, State <b>Halethorpe, MD</b>
---	--	--	--	--	-------------------------	--

21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>				
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Gunshot Wounds</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death
---	--	--	--	--	--	--

b. Due to (or as a consequence of):						
--	--	--	--	--	--	--

c. Due to (or as a consequence of):						
--	--	--	--	--	--	--

d.  <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED						
--	--	--	--	--	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 [ ] Yes 2 [ ] No 9 [ ] Unknown</b>		23c. If yes, outcome of pregnancy 1 [ ] Live birth    2 [ ] Fetal death    3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death    5 [ ] Other (Specify) _____ 9 [ ] Unknown			23d. Date of delivery Month Day Year		
--	--	--	--	--	---	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown</b>	
						24a. Was an autopsy performed? <b>1 [X] Yes 2 [ ] No</b>	
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 [X] Yes 2 [ ] No</b>	

25. Was case referred to medical examiner? <b>1 [X] Yes 2 [ ] No</b>		26. Place of Death (Check only one) Hospital: <b>1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA</b> Other: <b>4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other:</b>					
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27. Manner of Death 1 [ ] Natural    5 [ ] Pending Investigation 2 [ ] Accident    6 [ ] Could not be determined 3 [ ] Suicide    4 [X] Homicide		28a. Date of Injury (Month, Day, Year) <b>Aug 25, 2011</b>	28b. Time of Injury <b>0033 hrs</b>	28c. Injury at Work? <b>1 [ ] Yes 2 [X] No</b>	28d. Describe how injury occurred <b>Subject shot</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Sidewalk</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1200 Valley Street, Baltimore, MD</b>		

29a. Certifier (Check only one) <b>1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>O.C.M.E.</b>					
---	--	--	--	--	--	--	--

29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>August 25, 2011</b>					
---	--	---	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>							
--	--	--	--	--	--	--	--

31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					
---	--	-------------------------------	--	--	--	--	--

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28070

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

*Bruce*

*Harrison*

2. Date of Death

Month

Day

Year

1808 PM

3. Time of Death

4a. Facility Name (if not institution, give street and number)

*The Johns Hopkins Hospital*

4b. City, Town, or Location of Death

*Baltimore City*

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-89-8616

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

15 North East Ave.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: **Black**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) N/A

College (1-4 or 5+) N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business Industry

N/A

17. Father's Name (First, Middle, Last)

Rodney A. Harrison, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Sharlene Paul

19a. Informant's Name/Relationship (Type, Print)  
**Grand-Cynthia Harrison Mother**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**15 Neves Ct. Baltimore, MD 21234**

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

**King Memorial Pk.**

Date

9/3/2011

20c. Location - City or Town, State

**Randallstown, MD**

21. Signature of Funeral Service License

*[Signature]*

22. Name and Address of Facility

**March F/H 1101 E. North Ave. Baltimore, MD 21202**

Physician  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

**Hypoplastic left heart syndrome**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

PES-000

29d. Date signed (Month, Day, Year)

August 29, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Alex R. Walker, MD*

600 N. Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

*J. [Signature]*

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28071

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellen M. Hautanen</b>				2. Date of Death Month <b>Sept.</b> Day <b>1</b> Year <b>2011</b>	3. Time of Death 7:00 P M				
	4a. Facility Name (if not institution, give street and number) <b>FutureCare Northpoint Nursing Home</b>		4b. City, Town, or Location of Death <b>Baltimore Co.</b>		4c. County of Death <b>Baltimore Co.</b>					
Funeral Director	5. Social Security Number <b>532-20-8984</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>101</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day, Year) <b>May 16, 1910</b>	9. Birthplace (State or Foreign Country) <b>Finland</b>			
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>7740 South Cove Road</b>			10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>William Thomas Blitz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>unkn.</b> <b>Ida</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Vernon G. Mills (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7740 South Cove Road Edgemere, Maryland 21219</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Hilltop Service Corp.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Towson, Maryland</b>		Date <b>09/6/2011</b>	20c. Location - City or Town, State <b>Dundalk, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Michael J. Nein</b>		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>							
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>DEMENTIA</b>							Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of): <b>DEMENTIA</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>4 Nursing Home</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death <b>1 Natural</b> <b>5 Pending Investigation</b> <b>2 Accident</b> <b>6 Could not be determined</b> <b>3 Suicide</b> <b>4 Homicide</b>		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <b>LAWRENCE KELLY</b>					29c. License number <b>DO060580</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2, 2011</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LAWRENCE KELLY 9106, 14TH &amp; BELLEVUE RD #208, ROSEVILLE, MD</b>									
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>J. Barkal</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28072

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last) <b>ERMA HUNTER</b>			2. Date of Death Month Day Year <b>Aug 25 2011 150 PM</b>		3. Time of Death M
4a. Facility Name (If not institution, give street and number) <b>Seasons Hospice</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>215-52-0669</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>01/03/1943</b>
9. Usual Residence of Decedent <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>	
10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2434 W. Franklin Street</b>			10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Baltimore City School</b>	
17. Father's Name (First, Middle, Last) <b>David Faulcon Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Hunter</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Khadijah Ali (daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4900 West Hills Rd., Baltimore, MD 21229</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cem.</b>		Date <b>08/31/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee <b>Jacqueline E. Bear</b>			22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</b>		

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24-hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of): <b>Atherosclerotic Cardiovascular Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Erma Hunter</b>		29c. License number <b>015872</b>				29d. Date signed (Month, Day, Year) <b>Aug 26, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Horace Bob 6934 Aviation Blvd</b>							
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Erma E. Bear</b>					

## Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

## Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 20b per fh g919 9-6-11 vt

State of Maryland / Department of Health and Mental Hygiene

2011 28073

1- For State Registrar

## Certificate of Death

Reg. No.

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Elsie Mae Johnson</i>							2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <i>August 30 2011</i>	3. Time of Death 9:45 PM	
	4a. Facility Name (if not institution, give street and number) <i>Seasons Hospice &amp; NW Hospital</i>			4b. City, Town, or Location of Death <i>Randallstown</i>			4c. County of Death <i>Baltimore</i>			
<b>Funeral Director</b>	5. Social Security Number <i>214-40-7721</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>66 Yrs.</i>	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <i></i>	8. Date of Birth (Month, Day, Year) <i>02/06/1945</i>	9. Birthplace (State or Foreign Country) <i>MD</i>				
	Usual Residence of Decedent <i>MD Baltimore</i>			10a. State <i>MD</i>			10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Randallstown</i>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <i>9208 Liberty Road</i>			10f. Zip Code <i>21133</i>			10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i></i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 5th grade</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Verizon Dispatcher</i>			16b. Kind of Business/Industry <i>Verizon</i>			
	17. Father's Name (First, Middle, Last) <i>Walter Sheppard</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Pearl Robinson</i>						
	19a. Informant's Name/Relationship (Type, Print) <i>David Cannon / son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9208 Liberty Road Randallstown MD 21133</i>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>			Date <i>09/07/2011</i>	20c. Location - City or Town, State <i>Woodlawn, MD</i>		
<b>Physician/ Medical Examiner</b>	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 8728 Liberty Road Randallstown MD 21133</i>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death			
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> in-patient hospice						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			Date of injury (Month, Day, Year) <i></i>	Time of injury M <i></i>	Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i></i>	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>N.S. Rajapakse, M.D.</i>			29c. License number <i>D0057465</i>			29d. Date signed (Month, Day, Year) <i>8/31/11</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N.S. Rajapakse, M.D. 2835 Smith Av 5203 Baltimore MD 21209</i>									
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Laura A. Parker</i>							

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28074

1- For State  
Registrar

Reg. No.

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	Dramiara Johnson		2. Date of Death Month August 27, 2011 Year	3. Time of Death 1138 hrs
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**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)	Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore	4c. County of Death	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 4 Yrs.	If Under 1 Year Months    Days    Hours    Min.	8. Date of Birth (MM/DD/YYYY) 3/29/2007	9. Birthplace (State or Foreign Country) MD

**Baltimore, MD 21215-0036**  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To Be Completed by Funeral Director**

10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1730 Gorsuch Avenue	10f. Zip Code 21218	10g. Citizen of What Country? USA	

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0	College (1-4 or 5+) 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked	16b. Kind of Business/Industry Never Worked
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17. Father's Name (First, Middle, Last) Keith Gamble	18. Mother's Name (First, Middle, Maiden Surname) La Keya Johnson
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19a. Informant's Name/Relationship (Type, Print) Mr. Keith Gamble (Father)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1730 Gorsuch Ave. Balt., MD 21218
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery	Date 9/3/2011	20c. Location - City or Town, State Dundalk, MD
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21. Signature of Funeral Service Licensee Mlesley Charlo	22. Name and Address of Facility Joseph F. Russ Funeral Home, P.A. 2222 N. North Ave. Balt., MD 21216
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**Physician  
/Medical  
Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Head Injuries Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. _____ Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):	d. _____	
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED		

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans

**Medical Certification: To Be Completed by Physician/Medical Examiner**

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Aug 23, 2011	28b. Time of Injury 0100 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject beaten
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family Home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 1730 Gorsuch Avenue, Baltimore, MD

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 28, 2011
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30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature Lena P. Paula
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ATTEND ITEM 51 per DVR 6/9/9, 9/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28075

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 08 Day 27 Year 11		3. Time of Death 10:25a M	
James L. Jones					
4a. Facility Name (if not institution, give street and number) Genesis Randallstown Cr		4b. City, Town, or Location of Death Randallstown, MD		4c. County of Death Baltimore	
5. Social Security Number 213-36-7443		6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days Hours Min. 01 23 40	
8. Date of Birth (Month, Day, Year) 01 23 40		9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 X Yes 2 No					
10e. Street and Number 4131 Callaway Ave		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No Specify:	
15. Decedent's Education (Specify only highest grade completed) 11th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor		16b. Kind of Business Industry Children's Guild	
17. Father's Name (First, Middle, Last) Lewis Jones		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Thomas			
19a. Informant's Name/Relationship (Type, Print) Hattie Jones-Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4131 Callaway Ave, Baltimore, Md 21215			
20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 9/3/2011	20c. Location - City or Town, State Woodlawn, Md
21. Signature of Funeral Service Licensee ▶ S. Keke		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of): Severe Anemia</p> <p>b. Due to (or as a consequence of): End stage renal Disease</p> <p>c. Due to (or as a consequence of): failure to thrive</p> <p>d. _____</p>			
IF FEMALE: N/A		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery N/A Month Day Year	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
- Sacral decubitus ulcer					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 X Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) N/A	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier ▶ S. Keke MD		29c. License number D0072109		29d. Date signed (Month, Day, Year) 8/28/11	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAOIA N. BAON 9109 Liberty Road, Randallstown, Md 21133					
31. Date filed (Month, Day, Year) 8/28/11 SEP 06 2011		32. Registrar's Signature Leanne S. Parker			

ORIGINAL

## Certificate of Death

Reg. No. 2011 28076

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)		Johnson		2. Date of Death Month Day Year	3. Time of Death M
Norman Johnson				08 31 2011	4:20a.
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
526 Queensgate Road		Baltimore		Baltimore	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 01 08 61
219-80-5846					9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State MD 10b. County NA 10c. City, Town or Location Baltimore			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
526 Queensgate Road		21229		U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) na		16b. Kind of Business Industry Maintenance Supervisor Edgewood Management	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname) Charles R. Johnson Delores Gatlin			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debrah J. Johnson-Wife 526 Queensgate Road, Baltimore Md 21229			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 9/09/2011 9/7/2011 Woodlawn, Md	
21. Signature of Funeral Service Licensee <i>J. Lynn B. Keke</i>		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>METASTATIC PERITONEAL ADENOCARCINOMA TWO MONTHS</i>			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Stenker</i>		29c. License number 1D0061765		29d. Date signed (Month, Day, Year) 08-31-2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>EBENEZER QUAINOON 3350 WILKENS AVE #307 BALTIMORE MD</i>					
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature <i>Leanne D. Parker</i>			

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28077

## Certificate of Death

Reg. No.

1 - For State Registrar		Decedent's Name (First, Middle, Last)							Date of Death		Time of Death			
		Marcella Simmons Jones							Month Day Year		7:10 PM			
Physician/Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death					
		Baltimore Washington Medical Center			Glen Burnie				Anne Arundel					
Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
		577-60-0248		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	88 Yrs.	Months	Days	Hours	Min.	01/29/1923	SC			
To Be Completed by Funeral Director		10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits			
		MD		Anne Arundel		Annapolis					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?						
		3222 Henson Ave.			21403			USA						
To Be Completed by Physician/Medical Examiner		11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Black				
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry						
		Elementary/Secondary (0-12) 12			College (1-4 or 5+) Civil Servant			US Government						
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)							
		Unknown					Rosa Bell Simmons							
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			Date						
		Stephany R. Grillo / Daughter			1267 Crummell Ave., Annapolis, MD 21403			09/08/2011						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State						
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			Lincoln Mem. Cemetery			Suitland, MD						
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee			22. Name and Address of Facility			Approximate Interval Between Onset and Death						
		► Marcella Simmons			Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227									
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
		Immediate Cause (Final disease or condition resulting in death)												
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
		<p>a. <u>pneumonia</u> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>												
To Be Completed by Physician/Medical Examiner		IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery							
		23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy	4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	9 <input type="checkbox"/> Unknown	Month Day Year							
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
		<u>cerebrovascular accident</u>												
To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death?												
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed?												
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
To Be Completed by Physician/Medical Examiner		24b. Were autopsy findings available prior to completion of cause of death?												
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner?			26. Place of Death (Check only one)									
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner		27. Manner of Death			28a. Date of injury (Month, Day, Year)			28b. Time of injury			28c. Injury at work?		28d. Describe how injury occurred	
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)						
		► Dafna Koldobskiy			D 17692			Sept 2, 2011						
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
		Dafna Koldobskiy Baltimore Washington Medical Center 301 Hospital 1 Drive												
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year)			32. Registrar's Signature									
		SEP 06 2011			J. J. Parker						Glen Burnie, MD			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28078

Physician/  
Medical  
Examiner

Funeral  
Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>MILDRED JOHNSON</b>			2. Date of Death Month 8 Day 27 Year 2011	3. Time of Death 942 AM
4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>	
5. Social Security Number <b>226-26-2802</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>91</b>	8. Date of Birth (Month, Day, Year) <b>08 20 1920</b>
9. Birthplace (State or Foreign Country) <b>NC</b>		10. Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b>		
11. Street and Number <b>1360 Fenwick Lane #1206</b>			10f. Zip Code <b>20910</b>	10g. Citizen of What Country? <b>USA</b>
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Specify: Black</b>		
14. Race - American Indian, Black, White, etc. <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic Worker</b>			16b. Kind of Business Industry <b>Self Employed</b>	
17. Father's Name (First, Middle, Last) <b>Martin L. Ellis</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Onie Chambers</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Trudy Neely/Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>927 Faith Rd. Salisbury, NC 28146</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Jeanne C. LaFleur</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Memorial</b>	Date <b>09/02/2011</b>	20c. Location - City or Town, State <b>Suitland, MD</b>
21. Signature of Funeral Service Licensee <b>Jeanne C. LaFleur</b>		22. Name and Address of Facility <b>Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
<p>a. <b>Respiratory Failure</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Rumana Shameem, MD</b>		
		29c. License number <b>MD 31065</b>		29d. Date signed (Month, Day, Year) <b>09/01/2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rumana Shameem, MD 700 2nd Street, Washington, DC 20002</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>				
32. Registrar's Signature <b>Rumana Shameem</b>				

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28079

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Hannah JOHNSON</i>							2. Date of Death Month <i>Aug</i> Day <i>28</i> Year <i>2011</i>	3. Time of Death <i>3:45A M</i>		
	4a. Facility Name (if not institution, give street and number) <i>3032 Hanlon Ave</i>				4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death			
<b>Funeral Director</b>	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>103</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>10/07/1907</i>	9. Birthplace (State or Foreign Country) <i>VA</i>				
<b>To Be Completed by Funeral Director</b>	10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <i>3032 Hanlon Ave</i>				10f. Zip Code <i>21216</i>			10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>2yrs</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurse</i>			16b. Kind of Business Industry <i>Medical</i>				
	17. Father's Name (First, Middle, Last) <i>Morgan Brown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Bronson</i>						
	19a. Informant's Name/Relationship (Type, Print) <i>Corietha Ferebee Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3000 Towanda Ave Apt 216 Baltimore MD21215</i>						
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Atlantic Crem</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Atlantic Crem</i>			Date <i>8/31/11</i>	20c. Location - City or Town, State <i>Glen Burnie MD</i>				
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <i>Thomas E Allen</i>		22. Name and Address of Facility <i>Simplicity Crem &amp; Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD</i>								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Encephalitis Alzheimers Dementia</i>								Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <i>8/30/11</i>		28b. Time of injury <i>M</i>		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Baltimore MD 21215</i>								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>00657465</i>							29d. Date signed (Month, Day, Year) <i>8/30/11</i>	
	29b. Signature and title of certifier <i>N-S Rajapakse MD</i>										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N-S Rajapakse MD 2835 Smith St Baltimore MD 21203</i>										
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Anna J. Parker</i>								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68700

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28080

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)

Christanthi Kefalas

2. Date of Death

September 1, 2011

3. Time of Death

3:00P M

4a. Facility Name (if not institution, give street and number)

74 Avalon Avenue

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

216-36-6384

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

5-12-1912

9. Time of Death

3:00P M

4a. Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

MD

Baltimore

Dundalk

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

74 Avalon Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

John Mostris

18. Mother's Name (First, Middle, Maiden Surname)

Penelope Mostris

19a. Informant's Name/Relationship (Type, Print)

Daughter Tsambika Triantafilos-

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11222 Old Carriage Rd., Glen Arm, MD 21057

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

9-7-2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Bradley-Ashton Funeral Home

PA, 2134 Willow Spring Road 21222

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADVANCED ALZHEIMER DEMENTIA

Approximate Interval Between Onset and Death

10 yrs

Due to (or as a consequence of):

b. GENERAL DEBILITY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify) \_\_\_\_\_  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

74 PERTUSION

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DCA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural2  Pending Investigation3  Accident4  Suicide5  Homicide6  Could not be determined

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 17728

29d. Date signed (Month, Day, Year)

09-02-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BA YIN OUNG, M.D., 8022 BELAIR RD, BALTIMORE MD 21236

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28081

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>Jean Frances Kesterson</b>				2. Date of Death Month Sept. Day 1, Year 2011	3. Time of Death 6:50 A M
4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice Center</b>				4b. City, Town, or Location of Death <b>Towson</b>	
4c. County of Death <b>Baltimore Co.</b>					
5. Social Security Number <b>215-46-8385</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1946</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>7349 Hughes Avenue</b>			10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>12 Years</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	
14. Race - American Indian, Black, White, etc. Specify:					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cafeteria Worker</b>		16b. Kind of Business Industry <b>Baltimore County Public Schools</b>	
17. Father's Name (First, Middle, Last) <b>Bernard R. Saunders</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Frances L. Smith</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Melissa Sellers (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 Hyacinth Road Parkville, Maryland 21234</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Hilltop Service Corp.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>9/2/2011</b>	20c. Location - City or Town, State <b>Towson, Maryland</b>
21. Signature of Funeral Service Licensee <b>C.C. C. C. C.</b>		22. Name and Address of Facility <b>Buda-Kuck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Virosepsis - recurrent</b>				Approximate Interval Between Onset and Death <b>weeks</b>
a. Due to (or as a consequence of): <b>Virosepsis - recurrent</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
23b. Part 2. Enter conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b>		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred <b>Hospital</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Laura Patel MD</b>		
		29c. License number <b>D0070635</b>		29d. Date signed (Month, Day, Year) <b>9/11/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laura Patel 6701 N Charles St Suite 4105 Baltimore, MD 21205</b>				

31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Laura J. Patel</b>
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

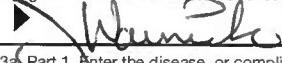
State of Maryland / Department of Health and Mental Hygiene

2011 28082

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DENNIS MICHAEL KAMMERER</b>							2. Date of Death Month Day Year <b>AUGUST 28, 2011</b>	3. Time of Death 11:30 A M	
	4a. Facility Name (if not institution, give street and number) <b>FUTURE CARE COLD SPRING</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>			
<b>Funeral Director</b>	5. Social Security Number <b>212-36-5313</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/9/1935</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>BALTIMORE</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>419 S. LEHIGH STREET</b>			10f. Zip Code <b>21214</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COLLEGE STUDENT</b>			16b. Kind of Business Industry <b>LIQUOR</b>			
	17. Father's Name (First, Middle, Last) <b>FLOYD KAMMERER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES UNKNOWN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>BEVERLY KAMMERER- WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>419 S. LEHIGH STREET BALTIMORE, MD 21224</b>					
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>ATLANTIC CREMATORY</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ATLANTIC CREMATORY</b>		Date <b>9/1/2011</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON</b> <b>6224 EASTERN AVENUE BALTIMORE, MD 21224</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>								Approximate Interval Between Onset and Death	
	23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>M</b>		28b. Time of injury <b>M</b>		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. License number <b>D0069314</b>	29d. Date signed (Month, Day, Year) <b>08/21/11</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mittal Rajapati 8813 Waltham Woods Rd Parkville MD 21234</b>								31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
	32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

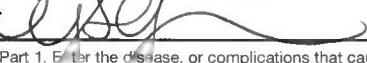
State of Maryland / Department of Health and Mental Hygiene

2011 28083

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HILLIARD LYONS</b>				2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2011</b>	3. Time of Death <b>0615 M</b>										
	4a. Facility Name (if not institution, give street and number) <b>10802 West Kettering Drive</b>				4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death <b>Prince George's</b>									
Funeral Director	5. Social Security Number <b>245-56-7913</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>April 11 1921</b>	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>									
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>PRINCE GEORGE'S</b> 10c. City, Town or Location <b>UPPER MARLBORO</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number <b>10802 W. KETTERING DRIVE</b>			10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business Industry <b>PRIVATE</b>										
	17. Father's Name (First, Middle, Last) <b>JIMMY LYONS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>IDA WEBB</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>HILLIARD A. LYONS/SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10802 W. KETTERING DRIVE UPPER MARLBORO, MARYLAND 20772</b>												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF GETHSEMANE</b>		Date <b>9/10/11</b>	20c. Location (City or Town, State) <b>NORTH CAROLINA ROCKY MOUNT</b>									
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME, INC.</b> <b>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>												
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
Medical Certificate: To Be Completed by Physician/Medical Examiner	a. Due to (or as a consequence of):  Atherosclerotic cardiovascular heart disease															
	b. Due to (or as a consequence of):															
	c. Due to (or as a consequence of):															
	d. Due to (or as a consequence of):															
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
													29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
													29b. Signature and title of certifier 		29c. License number <b>10055827</b>	29d. Date signed (Month, Day, Year) <b>September 2, 2011</b>
													30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Salvador Sylvestre 300 Hospital Drive Clarendon, Maryland</b>			
													31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28084

## Certificate of Death

Reg. No.

1 - For State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Annwar Lamar Lewis</i>					2. Date of Death Month <input checked="" type="checkbox"/> 08 Day 31 Year 11	3. Time of Death 1344 M			
	4a. Facility Name (if not institution, give street and number) <i>Union Memorial Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death				
Funeral Director	5. Social Security Number <i>168-60-3802</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>41</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth <i>6/22/1970</i>	9. Birthplace, State or Foreign Country <i>PA</i>		
	Usual Residence of Decedent 10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Windsor Mill</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <i>7104 Ruth green Road</i>			10f. Zip Code <i>21244</i>		10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>Elementary Secondary (0-12)</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <i>11th</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Restaurant Manager</i>			16b. Kind of Business Industry <i>MVD Enterprise</i>			
	17. Father's Name (First, Middle, Last) <i>Nathaniel Frisby</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Simmons Lewis</i>						
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Simmons Lewis (Mother)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1318 W. Somerset St, Philadelphia, PA 19132</i>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Vaughn C. Greene</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Green Mount</i>			Date <i>9/18/2011</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Name and Address of Facility <i>Greene Cremation Services, PA 5151 Balto</i>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Right Heart Failure</i>			23b. Due to (or as a consequence of): <i>Acute Respiratory Distress Syndrome</i>			Approximate Interval Between Onset and Death <i>1 year</i>			
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				
			28a. Date of injury (Month, Day, Year)			28b. Time of injury M			28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <i>AT2438946-C23</i>			29d. Date signed (Month, Day, Year) <i>08/31/11</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jillia Slater, MD</i>			31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>			32. Registrar's Signature <i>Jillia S. Slater</i>				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

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18  
State Registrar  
DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28085

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<b>Cassandra Anita Latney</b>		August 28, 2011		23:23 PM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<b>Southern Maryland Hospital</b>		<b>Clinton</b>		<b>PG</b>	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth Month Day Year	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
577-70-6547				10/05/1951	
Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
VA		<b>Stafford</b>			
10e. Street and Number <b>203 Appalachian Drive</b>		10f. Zip Code <b>22554</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Jasper H. Hoskins</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Barber</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Danielle Latney-Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Appalachian Drive; Stafford, VA 22554</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Chesapeake Crem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>		Date <b>09/03/2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>
21. Signature of Funeral Service Licensee <b>Danielle Freeman</b>		22. Name and Address of Facility <b>Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): <b>LUNG CANCER</b>					
b. Due to (or as a consequence of): <b>PANCREATIC CANCER</b>					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONIA</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Chike Onwuka</b>		29c. License number <b>D0064986</b>		29d. Date signed (Month, Day, Year) <b>8/29/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chike Onwuka, MD 7500 Surratts Road; Clinton, MD 20735</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>James J. Pace</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28086

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Oliver Long</b>					2. Date of Death Month Sep. 4, 2011 Day Year	3. Time of Death 5:15 P.M.		
	4a. Facility Name (if not institution, give street and number) <b>Dove House</b>			4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>217-26-7508</b>		6. Sex <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 2, 1932</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>			10d. Inside City Limits <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>127 Main Street</b>			10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>United States of America</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Delivery Man</b>			16b. Kind of Business Industry <b>Publications</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Henry Long</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Fowble</b>					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Patricia M. Long (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>127 Main Street, Reisterstown, MD 21136</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>John J. Murray</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Saints Cemetery</b>		Date <b>Sep. 8, 2011</b>	20c. Location - City or Town, State <b>Reisterstown, Maryland</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Home Licensee <i>John J. Murray</i>			22. Name and Address of Facility <b>Eckhardt Funeral Chapel, P.A.</b> <b>11605 Reisterstown Rd., Owings Mills, MD 21117</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <i>Chronic lymphocytic leukemia</i>			Approximate Interval Between Onset and Death		
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Due to (or as a consequence of):					
	23e. Due to (or as a consequence of):			23f. Due to (or as a consequence of):					
	23g. Due to (or as a consequence of):			23h. Due to (or as a consequence of):					
	23i. Due to (or as a consequence of):			23j. Due to (or as a consequence of):					
	23k. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23l. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23m. Date of delivery Month Day Year		
	23n. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23o. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			23p. 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Dove House</i>					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred <i>Dove House</i>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <b>D0071746</b>			29d. Date signed (Month, Day, Year) <b>9/5/11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Barbara J. Gaskins</i>			31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature <i>Barbara J. Gaskins</i>		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28087

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0005 hrs
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JEREMY WILLIAM LUTZ

August 29, 2011

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Rt. 70 East	4b. City, Town, or Location of Death Catonsville	4c. County of Death Baltimore County
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Usual Residence of Decedent

10a. State MD	10b. County HOWARD	10c. City, Town or Location WEST FRIENDSHIP	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number  
2574 WELLWORTH WAY10f. Zip Code  
2179410g. Citizen of What Country?  
U.S.A.

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry I + PLUMBING APPRENTICE
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17. Father's Name (First, Middle, Last) THOMAS WILLIAM LUTZ	18. Mother's Name (First, Middle, Maiden Surname) PAULETTE KELLY
--	---

19a. Informant's Name/Relationship (Type, Print) PAULETTE LUTZ	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2574 WELLWORTH WAY, WEST FRIENDSHIP, MD 21794
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: CREST LAWN MEMORIAL	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 09/02/2011	20c. Location - City or Town, State MARRIOTTSVILLE, MD
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21. Signature of Funeral Service Licensee Plumbers Son 20070	22. Name and Address of Facility SLACK FUNERAL HOME, P.A. 3871 OLD COLUMBIA PIKE, ELLICOTT CITY, MD 21043
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
--	--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
--	--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Aug 29, 2011	28b. Time of Injury 0005 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject lost control of motorcycle he was driving
--	---	---------------------------------	---	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway	28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 70 East, Catonsville, MD
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29b. Signature and title of certifier Victor Weeden MD JD Assistant Medical Examiner	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 29, 2011
---	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature Lorraine S. Jones
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State Registrar	ORIGINAL
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Please Type or Print in Black Ink Only. Ensure All Copies Are Legible.  
amend #18&19b Per FH G915 09/2011 TH  
State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No.

011 28088

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>DELORES LINTON</b>						2. Date of Death Month <b>08</b> Day <b>24</b> Year <b>2011</b>		3. Time of Death <b>3:24P M</b>	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Genesis Loft Raven</b>			4b. City, Town, or Location of Death <b>Baltimore, MD</b>			4c. County of Death <b>BALTIMORE</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>218-44-9959</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>5/13/1943</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number <b>4403 Green Rose Lane</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>N/A</b>		16b. Kind of Business Industry <b>Teachers Aide</b>			16c. Date of Death (First, Middle, Maiden Surname) <b>Estelle Searles</b>		
		17. Father's Name (First, Middle, Last) <b>John Alfred Makel</b>							18. Mother's Name (First, Middle, Maiden Surname) <b>Estella Searles</b>		
		19a. Informant's Name/Relationship (Type, Print) <b>Leo Linton, Jr.-Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Spry Island 334 Spry Island Rd Joppa, MD 21085</b>							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>► B C L + r</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>		Date <b>8/30/2011</b>	20c. Location - City or Town, State <b>Halethorpe, MD</b>				
		21. Signature of Funeral Service Licensee <b>► B C L + r</b>		22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): <b>STG IV Small cell lung cancer &amp; Brain Mets Larangoal cancer</b>			23d. Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>► M. Bakr CNP</b>		29c. License number <b>R150259</b>		29d. Date signed (Month, Day, Year) <b>8/24/2011</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mariam Bakr CNP 8720 EM6E rd Baltimore MD 21234</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>► Sean J. Farley</b>									
State Registrar											

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

## Medical Certificate: To Be Completed by Physician/Medical Examiner

te  
ar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Physician Medical Examiner		1- For State Registrar						Reg. No. 2011 28089				
		1. Decedent's Name (First, Middle, Last) <b>Dashawn M. Monroe</b>			2. Date of Death Month Day Year August 28, 2011			3. Time of Death 0317 hrs				
		4a. Facility Name (if not institution, give street and number) <b>Howard County General Hospital</b>			4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>				
Funeral Director		5. Social Security Number <b>215-23-4074</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>22 Yrs.</b>	If Under 1 Year Months <b>22</b>	If Under 24Hrs. Days <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>Jan 17, 1989</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
To Be Completed by Funeral Director		10a. State <b>MD</b> 10b. County <b>Howard</b> 10c. City, Town or Location <b>Columbia</b>						10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>				
		10e. Street and Number <b>9687 Basketring Rd</b>			10f. Zip Code <b>21045</b>			10g. Citizen of What Country? <b>USA</b>				
		11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>					
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>Food Service</b>				
		17. Father's Name (First, Middle, Last) <b>Willie Monroe</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Schrhonda Myers</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Schrhonda Myers</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15495 Cedar Ln #301, Columbia, MD 20144</b>							
Physician /Medical Examiner		20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <b>Olegar Burek</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ardent Crematory</b>			Date <b>9/9/2011</b>	20c. Location - City or Town, State <b>Hanover, MD</b>					
		21. Signature of Funeral Service Licensee <b>Olegar Burek</b>			22. Name and Address of Facility <b>Howell Funeral Home 10220 Guilford Rd., Jessup MD 20794</b>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Occlusive Pulmonary Thromboembolism</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.						Approximate Interval Between Onset and Death				
		<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>				
								24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
		25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other</b>								
		27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>(Specify)</b>	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred  28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify)</b>					
							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>(Check only one)</b> 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier <b>Ana Rubio MD</b>		29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 28, 2011</b>					
		30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>										
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Laura J. Fahey</b>								

## Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28090

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 9:55AM
Charles Morgan		August 31 2011		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Northwest Hospital		Randallstown		Baltimore
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 25, 1927
241-34-4932				9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent		10a. State MD 10b. County Baltimore 10c. City, Town or Location Baltimore		
		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6213 Robin Hill Rd		10f. Zip Code 21207		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates Army	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16b. Kind of Business Industry Western Electric
17. Father's Name (First, Middle, Last) Luther Holder		18. Mother's Name (First, Middle, Maiden Surname) Zola Morgan		
19a. Informant's Name/Relationship (Type, Print) Almeta Morgan		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6213 Robin Hill Rd, Balto. MD 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State 9/9/2011 Owings Mills, MD
21. Signature of Funeral Service Licensee ► Brian R. Howell		22. Name and Address of Facility Howell Funeral Home 14600 Liberty Heights Ave, Balto. MD		
<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p><b>SEPSIS</b></p> <p>a. Due to (or as a consequence of): HOSPITAL ACQUIRED PNEUMONIA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
<p>IF FEMALE:</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____</p> <p>23d. Date of delivery Month Day Year</p>				
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>DEMENTIA, PULMONARY EMBOLISM</b></p> <p><b>CHRONIC ANEMIA</b></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DS4288		
29b. Signature and title of certifier ► Rangarajan MD		29d. Date signed (Month, Day, Year) August 31 2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramaswamy I RANGARAJAN		NORTHWEST HOSPITAL CENTER		
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Anna J. Park		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28091

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>PENELOPE ANN McLean</b>				2. Date of Death Month <b>08</b> Day <b>31</b> Year <b>2011</b>		3. Time of Death <b>11:50P M</b>	
		4a. Facility Name (if not institution, give street and number) <b>GILCHRIST HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director		5. Social Security Number <b>213-86-2185</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>10-25-1963</b>	9. Birthplace (State or Foreign Country) <b>NC</b>
		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director		10e. Street and Number <b>206 ST. MATTHEWS STREET</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPING</b>		16b. Kind of Business Industry <b>JOHN HOPKINS</b>			
		17. Father's Name (First, Middle, Last) <b>CHARLES COTTON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY McLEAN</b>					
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) <b>MARY McLEAN (MOTHER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 ST. MATTHEWS ST. BALTIMORE, MD. 21202</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>►/TJS 10/15/11</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDEN OF FAITH</b>		Date <b>9/18/2011</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee <b>►/TJS 10/15/11</b>		22. Name and Address of Facility <b>VAUGHN GREENE FUNERAL SERVICES 4905 YORK ROAD. BALTIMORE, MD. 21212</b>					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>months</b>			
To Be Completed by Physician/Medical Examiner		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6701 N Charles St Baltimore MD</b>			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D58303</b>		29d. Date signed (Month, Day, Year) <b>September 1 2011</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aaron J. James 110 6701 N Charles St Baltimore MD</b>		32. Registrar's Signature <b>Anna J. Parker</b>					
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Anna J. Parker</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28092

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Patient known as Frank Murphy  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<b>FRANK ARNOLD MURPHY</b>		September 1 2011		01:16A M
4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore city</b>		4c. County of Death
5. Social Security Number <b>243-50-8205</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) <b>1-5-1938</b>
9. Birthplace (State or Foreign Country) <b>N.C. Carolina</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State <b>MD</b>	10b. County	10c. City, Town or Location <b>Gwynn Oak</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>60 years</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) <b>Pastor</b>	16b. Kind of Business Industry <b>Church</b>		
17. Father's Name (First, Middle, Last) <b>Charlie Murphy</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Leola Baker</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Wilhelmina Murphy (Wife)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3214 Burningwell Rd. Gwynn Oak, MD 21207</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>King Memorial Park 9/6/2011</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Vaughn Cemetery Funeral Services</b>	Date <b>9/6/2011</b>	20c. Location - City or Town, State <b>Balto. MD</b>	
21. Signature of Funeral Service Licensee <b>Prayanka Iyer</b>	22. Name and Address of Facility <b>4905 York Rd. Balt MD 21212</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary embolism</b>				Approximate Interval Between Onset and Death <b>6 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Tachycardia</b>	a. Due to (or as a consequence of): <b>Tachycardia</b>			
	b. Due to (or as a consequence of): <b>Hypertension</b>			
	c. Due to (or as a consequence of): <b>Non-insulin dependant diabetes mellitus</b>			
	d. Due to (or as a consequence of): <b>Hyperlipidemia</b>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year) <b>September 1 2011</b>	28b. Time of injury <b>M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number <b>RES - 000</b>			
29b. Signature and title of certifier <b>Prayanka Iyer</b>	29d. Date signed (Month, Day, Year) <b>September 1, 2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PRAYANKA IYER, MBBS Sinai Hospital of Baltimore</b>	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			
32. Registrar's Signature <b>Prayanka Iyer</b>		33. Signature <b>Prayanka Iyer</b>		

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

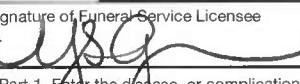
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28093

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BEULAH W. MONROE</b>					2. Date of Death Month <b>AUGUST</b> Day <b>30</b> Year <b>2011</b>	3. Time of Death <b>2:19 P M</b>			
	4a. Facility Name (if not institution, give street and number) <b>PRINCE GEORGE'S HOSPITAL</b>			4b. City, Town, or Location of Death <b>CHEVERLY</b>			4c. County of Death <b>PRINCE GEORGE'S</b>			
Funeral Director	5. Social Security Number <b>428-98-9398</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>65</b>	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <b>SEPT. 10 1945</b>	9. Birthplace (State or Foreign Country) <b>MISSISSIPPI</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>PRINCE GEORGE'S</b> 10c. City, Town or Location <b>UPPER MARLBORO</b> 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	10e. Street and Number <b>1304 PICKERING CIRCLE</b>			10f. Zip Code <b>20772</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LEGAL INSTRUMENT EXAMINER</b>			16b. Kind of Business Industry <b>GOVERNMENT</b>				
	17. Father's Name (First, Middle, Last) <b>WILLIE ALBERT WHITE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>A. Q. ALLEN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>WILLIE L. MONROE/HUSBAND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1304 PICKERING CIRCLE UPPER MARLBORO, MARYLAND 20774</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GEORGE WASHINGTON</b>		Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>ADELPHIA, MARYLAND</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME, INC.</b> <b>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>2 mths</b>		
	<p>a. Due to (or as a consequence of): <b>Respiratory failure</b></p> <p>b. Due to (or as a consequence of): <b>Laryngeal stridor</b></p> <p>c. Due to (or as a consequence of): <b>Vocal cord paralysis</b></p> <p>d. _____</p>							<b>2 mths</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ventricular tachycardia</b> <b>Hypertensive cardiovascular disease</b>							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D27521</b>			29d. Date signed (Month, Day, Year) <b>Aug 31, 2011</b>				
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KADIE E. LEACHT MD</b>									
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28094

1 - For  
State  
Registrar

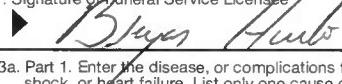
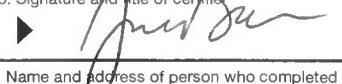
**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036  
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**Physician/  
Medical  
Examiner**

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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month AUGUST Day 30 Year 2011		3. Time of Death 6:28 P M
CLARENCE MARCELLE		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
4a. Facility Name (if not institution, give street and number) HOLY CROSS HOSPITAL		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
5. Social Security Number 101-20-9940		6. Sex <input checked="" type="checkbox"/> XX <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 1, 1928
9. Birthplace (State or Foreign Country) New York				
10a. State MD		10b. County Montgomery	10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 1412 Mimosa Lane		10f. Zip Code 20904		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) New York Transit Authority	16b. Kind of Business Industry Government	
17. Father's Name (First, Middle, Last) Gerald Marcelle		18. Mother's Name (First, Middle, Maiden Surname) Etta Vickers		
19a. Informant's Name/Relationship (Type, Print) Dorine Jennings / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Mimosa Lane Silver Springs, MD 20904		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery	Date 9/13/2011	20c. Location - City or Town, State Cheltenham, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <b>Coronary Artery Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death 10 Years				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number D21370		29d. Date signed (Month, Day, Year) September 2, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass, M.D. 15225 Shady Grove Road #302 Rockville, Maryland 20850				
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28095

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>JOHN H. MERENDA</b>				2. Date of Death Month <b>AUGUST</b> Day <b>31</b> , Year <b>2011</b>	3. Time of Death <b>9:30 P.M.</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>1302 WALKER AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>213-14-5202</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month/Day/Year) <b>6/25/1918</b>	9. Birthplace (State or Foreign) <b>MARYLAND</b>	
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>1302 WALKER AVENUE</b>			10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b> <b>10TH GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BARBER</b>			16b. Kind of Business Industry <b>OWN SHOP</b>		
		17. Father's Name (First, Middle, Last) <b>SANTI MERENDA</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CARMELLA UNAVAILABLE</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>LORENE T. MERENDA/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1302 WALKER AVENUE BALTIMORE, MD 21239</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>GARRISON FOREST VET. CEMETERY</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST VET. CEMETERY</b>		Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>		
		21. Signature of Funeral Service Licensee <b>MOO217</b>		22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A.</b> <b>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>					
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive heart failure</b>						Approximate Interval Between Onset and Death	
		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>R125808</b>					
		29b. Signature and title of certifier <b>Anne Lewis CRNP</b>		29d. Date signed (Month, Day, Year) <b>9/2/2011</b>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anne Lewis CRNP 6701 N. Charles St. Suite 4105, Towson MD 21204</b>							
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Leanne J. Powell</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28096

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Miller, Gregory  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>9</u> Day <u>1</u> Year <u>2011</u>			3. Time of Death <u>12:00P M</u>
<u>Gregory P. Miller</u>					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death <u>Rosedale</u>			4c. County of Death <u>Baltimore</u>
Franklin Square Hospital center					
5. Social Security Number <u>216-66-6997</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>57</u> Yrs.	If Under 1 Year Months <u>0</u> Days <u>0</u>	If Under 24 Hrs. Hours <u>0</u> Min. <u>0</u>
				8. Date of Birth (Month, Day, Year) <u>June 28, 1954</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
Usual Residence of Decedent		10c. City, Town or Location <u>Rosedale</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>			
10e. Street and Number <u>5405 Balistan Road</u>		10f. Zip Code <u>21237</u>			10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Seconday (0-12) 12th. Grade</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Service Technician</u>			16b. Kind of Business Industry <u>BGE</u>
17. Father's Name (First, Middle, Last) <u>Joseph</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Miller</u> <u>Jeanette</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Patricia Miller/Wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5405 Balistan Road Baltimore MD 21237</u>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Atlantic Crematory</u>		Date <u>09/04/2011</u>	20c. Location - City or Town, State <u>Glen Burnie MD</u>
21. Signature of Funeral Service Licensee <u>Diane Ricker</u>		22. Name and Address of Facility <u>Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 21206</u>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death
		a. <u>Respiratory failure</u> Due to (or as a consequence of)			
		b. <u>Cardiac failure</u> Due to (or as a consequence of)			
		c. <u>Severe sepsis secondary to pneumonia</u> Due to (or as a consequence of):			
		d. <u>Neutropenia Secondary to chemotherapy</u>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <u>Asima Rabman</u>		29c. License number <u>Res0000</u>			29d. Date signed (Month, Day, Year) <u>9-1-2011</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Asima Rabman MD, 9000 Franklin Square Drive, Baltimore MD 21237					
31. Date filed (Month, Day, Year) <u>SEP 06 2011</u>		32. Registrar's Signature <u>Asima J. Rabman</u>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28097

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hannah Anna Morris</b>						2. Date of Death Month Day Year <b>August 31, 2011</b>	3. Time of Death 0935 M			
	4a. Facility Name (if not institution, give street and number) <b>Casey House</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>				
Funeral Director	5. Social Security Number <b>217-30-7007</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 15, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent		10a. State <b>MD</b>			10b. County <b>Prince George's</b>			10c. City, Town or Location <b>Lanham</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>9023 2nd Street</b>			10f. Zip Code <b>20706</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Book Binder</b>				16b. Kind of Business Industry <b>Printing</b>			
17. Father's Name (First, Middle, Last) <b>Albert George Dabbs</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Careen McCoy</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Weldon Thomas Morris, Jr./son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3409 University Blvd. W, #201 Kensington, MD 20895</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Final Journey Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>09/01/11</b>			Date <b>09/01/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>				
21. Signature of Funeral Service Licensee <b>Beverly L Heckrote</b>				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Peripheral Vascular Disease</b> Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Right Above Knee Amputation</b> Due to (or as a consequence of): <b>Coronary Artery Disease</b> Due to (or as a consequence of):											
23b. If Female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Bindu Joseph, M.D.</b>		29c. License number <b>D60634</b>			29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bindu Joseph, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>James J. Parker</b>									

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

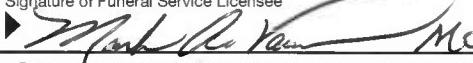
Reg. No. 2011 28098

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

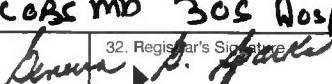
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Richard M. Mundella</b>							2. Date of Death Month <b>September</b> Day <b>2</b> , Year <b>2011</b>	3. Time of Death <b>3:07 P M</b>
4a. Facility Name (if not institution, give street and number) <b>Baltimore Washington Medical Center</b>							4b. City, Town, or Location of Death <b>Glen Burnie</b>	4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>104-32-1155</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months <b>05</b> Days <b>08</b>	If Under 24 Hrs. Hours <b>19</b> Min. <b>01</b>	8. Date of Birth (Month, Day, Year) <b>05/08/1941</b>	9. Birthplace (State or Foreign Country) <b>NY</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Glen Burnie</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>1006 Stane Road</b>				10f. Zip Code <b>21060</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>			16b. Kind of Business Industry <b>Housing</b>	
17. Father's Name (First, Middle, Last) <b>Michael Mundella</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Adeline Meranda</b>				
19a. Informant's Name/Relationship (Type, Print) <b>brother</b> <b>Mr. Michael R. Mundella, Sr. /</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14810 Frog Hallow Road, Old Town, Maryland 21555</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Atlantic Crematory</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/4/2011</b>	20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>MO/357</b>				22. Name and Address of Facility <b>1 2nd Ave, SW Glen Burnie, MD</b> <b>Singleton Funeral &amp; Cremation Services, P.A.</b>				

Division of Vital Records, P.O. Box 68760

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Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>2 hours</b>	
<p>a. Due to (or as a consequence of): <b>Cardiogenic shock</b></p> <p>b. Due to (or as a consequence of): <b>Acute myocardial infarction</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>Unknown</b>				23d. Date of delivery Month <b>Day</b> <b>Year</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Type II Diabetes, hyperlipidemia</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0022483</b>				29d. Date signed (Month, Day, Year) <b>September 2, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart Jacobs MD 305 Hospital Dr. Glen Burnie, MD 21061</b>							
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

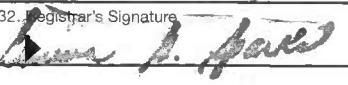
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28099

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Sylvia McCray</i>				2. Date of Death Month <b>08</b> Day <b>23</b> Year <b>2011</b>		3. Time of Death <b>8:12 AM</b>																				
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>University of Maryland Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <b>N/A</b>																				
To Be Completed by Funeral Director		5. Social Security Number <b>212-46-5345</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>2/6/1947</b>	9. Birthplace (State or Foreign Country) <b>MD</b>																				
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																			
		10e. Street and Number <b>1132 Stoddard St.</b>				10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>USA</b>																				
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business Industry <b>Factory</b>																				
		17. Father's Name (First, Middle, Last) <b>Johnnie McCray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Chandler</b>																						
		19a. Informant's Name/Relationship (Type, Print) <b>Debbie Void- Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4103 Maribin Ct. Balto., MD 21225</b>																						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Pk.</b>		Date <b>9/1/2011</b>	20c. Location - City or Town, State <b>Randallstown, MD</b>																					
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>																						
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																										
		<table border="1"> <tr> <td>a.</td> <td><i>Sepsis</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								a.	<i>Sepsis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.			c.			d.									
a.	<i>Sepsis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death																										
b.																												
c.																												
d.																												
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year																				
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic Nonsmall Cell Lung cancer</i> <i>Stroke with hemorrhagic conversion</i> <i>End stage Renal Disease</i>																										
		<table border="1"> <tr> <td colspan="2">26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA</td> <td colspan="2">Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</td> <td>28a. Date of injury (Month, Day, Year)</td> <td>28b. Time of injury M</td> <td>28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="3">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred																							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																								
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																										
		29b. Signature and title of certifier  <i>Carina Sorenson MD</i>				29c. License number <b>UMMC #202564</b>		29d. Date signed (Month, Day, Year) <b>08/23/2011</b>																				
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature  <i>Anna J. Sorenson</i>																								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28100

1 - For State Register		1. Decedent's Name (First, Middle, Last) <b>Irene McCrorey</b>						2. Date of Death Month 8 / Day 27 / Year 2011	3. Time of Death 7:25 a M		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice</b>						4b. City, Town, or Location of Death <b>Towson</b>	4c. County of Death <b>Baltimore</b>		
		5. Social Security Number <b>219-32-6185</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>7/26/1930</b>	9. Birthplace (State or Foreign Country) <b>S.C.</b>			
Funeral Director		10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		10e. Street and Number <b>1229 W. Saratoga St.</b>		10f. Zip Code <b>21223</b>			10g. Citizen of What Country? <b>USA</b>				
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>N/A</b>		16b. Kind of Business/Industry <b>Nurse Assistant</b>					
17. Father's Name (First, Middle, Last) <b>John Horsey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Hood</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Annette Robinson-Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 Wyndham Circle Baltimore, MD 21117</b>									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>► Brian Clegg</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>Owings Mills, MD</b>						
21. Signature of Funeral Service Licensee <b>► Brian Clegg</b>		22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>PANCREATIC CANCER</b>							Approximate Interval Between Onset and Death		
Physician/ Medical Examiner		a.	Due to (or as a consequence of):								
		b.	Due to (or as a consequence of):								
		c.	Due to (or as a consequence of):								
		d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DELIRIUM</b>									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									29c. License number <b>D72139</b>		29d. Date signed (Month, Day, Year) <b>08-27-11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6701 N CHARLES STREET SUITE 4105 BALTIMORE, MD 21204.</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Anna J. Lovell</b>									

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 2810

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Urias H. Mark

2. Date of Death

Month August Day 23 Year 2011

3. Time of Death

2:23 a M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

N/A

6. Sex

M

F

7. Age (In yrs. last birthday)

78

Yrs.

8. If Under 1 Year

Months

9. If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month Day Year)

9. Birthplace (State or Foreign Country)

St. Vincent

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

Yes  No

10e. Street and Number

3118 Harvey Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

Trinidad

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) 5th

College (1-4 or 5+) N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Prop Manager

16b. Kind of Business Industry

Television Station

17. Father's Name (First, Middle, Last)

William Mark

18. Mother's Name (First, Middle, Maiden Sumame)

Agathe Mark

19a. Informant's Name/Relationship (Type, Print)

Patricia Lawrence- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3118 Harvey Ave. Baltimore, MD 21234

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cent.

Date

8/29/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

► Smurton

22. Name and Address of Facility

March F/H 1101 E. North Ave. Baltimore, MD 21202

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Adult Respiratory Distress Syndrome

Bilateral Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

24a. Was an autopsy performed?  
 Yes  No

24b. Were autopsy findings available prior to completion of cause of death?  
 Yes  No

25. Was case referred to medical examiner?

Yes  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Rama Vunnam, MD

29c. License number

89670

29d. Date signed (Month, Day, Year)

08/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kama Vunnam, M.D. Go Maryland General Hospital

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

► James J. Farley

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For Amend Items 23a, 25, 27 per me, g918, 08/31/2011dhp  
State Registrar

2011 28102

## Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Roy Mobley</i>				2. Date of Death Month Day Year <i>August 22 2011</i>	3. Time of Death 11:15 AM			
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore City</i>	4c. County of Death N/A					
Funeral Director	5. Social Security Number <i>213-46-1660</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>64 Yrs.</i>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <i>5/26/1947</i>	9. Birthplace (State or Foreign Country) <i>S.C.</i>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>N/A</i>				10c. City, Town or Location <i>Baltimore</i>				
	10e. Street and Number <i>1547 N. Abbotston St.</i>				10f. Zip Code <i>21218</i>	10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>N/A</i>	16b. Kind of Business Industry <i>Disabled</i>						
	17. Father's Name (First, Middle, Last) <i>Willie James Mobley</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Lucinda Mobley</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Delores Mobley</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1547 N. Abbotson St. Baltimore, MD 21218</i>						
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Cemt.</i>	Date <i>8/29/2011</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>				
	21. Signature of Funeral Service Licensee <i>Jerry L. Mobley</i>		22. Name and Address of Facility <i>March F/H 1101 E. North Ave. Baltimore, MD 21202</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter underlying cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death Days		
		<i>Subdural hematoma</i>					<i>7 days</i>		
		<i>Multifactorial Coagulopathy</i>					<i>Days</i>		
		<i>Due to (or as a consequence of):</i>					<i>7 days</i>		
		<i>Due to (or as a consequence of):</i>					<i>7 days</i>		
		<i>Due to (or as a consequence of):</i>					<i>7 days</i>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>Joshua Kornbluth</i>		29c. License number <i>D72787</i>					29d. Date signed (Month, Day, Year) <i>August 22, 2011</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joshua Kornbluth 600 N Wolfe St. Baltimore, MD 21287</i>									
31. Date filed (Month, Day, Year) <i>AUG 31 2011</i>		32. Registrar's Signature <i>Anna B. Parker</i>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

#23A at H27 Fox to Me  
Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

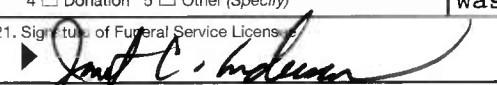
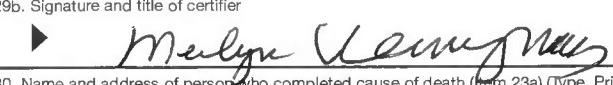
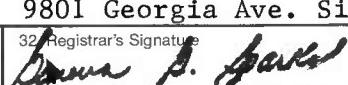
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28103  
Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>  <b>Funeral Director</b>  <b>To Be Completed by Funeral Director</b>  <b>Physician/ Medical Examiner</b>  <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Verneda B. Major</b>				2. Date of Death Month <b>08</b> Day <b>24</b> Year <b>2011</b>	3. Time of Death <b>9:00 A M</b>				
	4a. Facility Name (if not institution, give street and number) <b>Manor Care- Wheaton</b>		4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>					
<small>Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small>	5. Social Security Number <b>087-12-7378</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F <b>91</b> Yrs.		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. If Under 1 Year Months <b>08</b> Days <b>23</b> Hours <b>1920</b> Min.		9. Birthplace (State or Foreign Country) <b>PA</b>	
	10a. State <b>DC</b>		10b. County		10c. City, Town or Location <b>Washington</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>5206 1st St. NW</b>			10f. Zip Code <b>20011</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business Industry <b>Secretary</b>		16c. Date of Death <b>08/30/2011</b>			
	17. Father's Name (First, Middle, Last) <b>Raymond Wood</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Spell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Maxine E. Kelly/Friend</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5200 N. Capitol St. NW Washington, DC 20011</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington National</b>		20c. Date <b>08/30/2011</b>		20d. Location - City or Town, State <b>Suitland, MD</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Marshall-March Funeral Home</b> <b>4217 9th St. NW Washington, DC 20011</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death		
a. <b>End Stage Dementia</b> Due to (or as a consequence of):								<b>6 months</b>		
b. <b>Failure to Thrive</b> Due to (or as a consequence of):										
c. _____ Due to (or as a consequence of):										
d. _____ Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month <b>Day</b> <b>Year</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 								
29c. License number <b>D35791</b>		29d. Date signed (Month, Day, Year) <b>08/26/2011</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Merlyn Vermury, MD 9801 Georgia Ave. Silver Spring, MD 20902</b>										
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 								

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28104

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Brian Robertson

Murphy

2. Date of Death

Month  
09Day  
02Year  
20113. Time of Death  
8:35AM MFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice Center

4b. City, Town, or Location of Death  
Towson4c. County of Death  
Baltimore

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5. Social Security Number

218-60-5958

Usual Residence of Decedent

6. Sex

 M2  F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

03/12/1952

9. Birthplace (State or Foreign Country)

MD

10a. State

10b. County

MD

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

 Yes  No

10e. Street and Number

2824 Pinewood Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Computer Analyst

16b. Kind of Business/Industry

Information Systems

17. Father's Name (First, Middle, Last)

Paul

James

Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Margaret

Robertson

19a. Informant's Name/Relationship (Type, Print)

Debra Murphy, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2824 Pinewood Avenue, Baltimore, MD 21214

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Svc. Corp.

Date

09/06/2011

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

► Alexander R. Blain

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road, Baltimore, MD 21214

Physician/  
Medical  
Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
 hepatic Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
1  Yes 2  NoHospital:  
1  Inpatient 2  ER/Outpatient 3  DOAOther:  
4  Nursing Home 5  Residence 6  Other (Specify)

hospice

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 3  Suicide 6  Could not be determined  
3  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M 28c. Injury at work?  
1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Charles

29c. License number

DS8303

29d. Date signed (Month, Day, Year)

September 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW J CHARLES 6701 N. CHARLES ST TOWSON MD

31. Date filled (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

▶ Andrew J. Charles

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28105

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

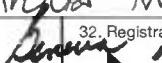
Baltimore, Maryland 21215-0036  
 Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department. If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Sally Henry Murray</b>			2. Date of Death Month <b>September</b> Day <b>2</b> , Year <b>2011</b>	3. Time of Death <b>11:10 am</b>
4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>	
4c. County of Death <b>Baltimore</b>				
5. Social Security Number <b>213-28-9031</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months      Days      Hours      Min.
8. Date of Birth (Month, Day, Year) <b>July 11, 1929</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>615 Chestnut Avenue, Apt 1324</b>			10f. Zip Code <b>21204</b>	10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Executive Secretary</b>		16b. Kind of Business/Industry <b>P.H. &amp; H.</b>
17. Father's Name (First, Middle, Last) <b>Don R. Henry</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Schwartz</b>	
19a. Informant's Name/Relationship (Type, Print) <b>E. Drennan Nickerson-daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>318 Presway Rd., Timonium, MD 21093</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Serv Corp</b>		Date <b>9/6/11</b>
20c. Location - City or Town, State <b>Towson, MD</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc.</b> <b>1050 York Rd., Towson, MD 21204</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <b>Primary peritoneal serous carcinoma</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death <b>months</b>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month      Day      Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>D58303</b>		29d. Date signed (Month, Day, Year) <b>September 2 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan J. Charnas MD 6701 N. Charles St Towson MD</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar/Signer 		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28106

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Guy J. Matricciani, Sr.</b>			2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2011</b>		3. Time of Death <b>1:30 a M</b>	
4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>218-07-5541</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Hours <b> </b>	Min. <b> </b>
8. Date of Birth (Month, Day, Year) <b>Feb 6, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>		
10e. Street and Number <b>1055 West Joppa Road, # 312</b>			10f. Zip Code <b>21204</b>			10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (14 or 5+) 5 Contractor</b>		16b. Kind of Business/Industry <b>Utility &amp; Paving</b>		
17. Father's Name (First, Middle, Last) <b>John Matricciani</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lucia Ferretti</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Guy J. Matricciani, Jr. - son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1663 Bullock Circle, Owings Mills, MD 21117</b>			
20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b></b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park</b>		Date <b>9/6/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>William G. Dau</b>		22. Name and Address of Facility <b>1050 York Rd., Towson, MD 21204 Ruck Towson Funeral Home, Inc.</b>				

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>		Approximate Interval Between Onset and Death <b>Days</b>
<b>a.</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  <b>e.</b> Due to (or as a consequence of):  <b>f.</b> Due to (or as a consequence of):  <b>g.</b> Due to (or as a consequence of):  <b>h.</b> Due to (or as a consequence of):  <b>i.</b> Due to (or as a consequence of):  <b>j.</b> Due to (or as a consequence of):  <b>k.</b> Due to (or as a consequence of):  <b>l.</b> Due to (or as a consequence of):  <b>m.</b> Due to (or as a consequence of):  <b>n.</b> Due to (or as a consequence of):  <b>o.</b> Due to (or as a consequence of):  <b>p.</b> Due to (or as a consequence of):  <b>q.</b> Due to (or as a consequence of):  <b>r.</b> Due to (or as a consequence of):  <b>s.</b> Due to (or as a consequence of):  <b>t.</b> Due to (or as a consequence of):  <b>u.</b> Due to (or as a consequence of):  <b>v.</b> Due to (or as a consequence of):  <b>w.</b> Due to (or as a consequence of):  <b>x.</b> Due to (or as a consequence of):  <b>y.</b> Due to (or as a consequence of):  <b>z.</b> Due to (or as a consequence of):  <b>aa.</b> Due to (or as a consequence of):  <b>bb.</b> Due to (or as a consequence of):  <b>cc.</b> Due to (or as a consequence of):  <b>dd.</b> Due to (or as a consequence of):  <b>ee.</b> Due to (or as a consequence of):  <b>ff.</b> Due to (or as a consequence of):  <b>gg.</b> Due to (or as a consequence of):  <b>hh.</b> Due to (or as a consequence of):  <b>ii.</b> Due to (or as a consequence of):  <b>jj.</b> Due to (or as a consequence of):  <b>kk.</b> Due to (or as a consequence of):  <b>ll.</b> Due to (or as a consequence of):  <b>mm.</b> Due to (or as a consequence of):  <b>nn.</b> Due to (or as a consequence of):  <b>oo.</b> Due to (or as a consequence of):  <b>pp.</b> Due to (or as a consequence of):  <b>qq.</b> Due to (or as a consequence of):  <b>rr.</b> Due to (or as a consequence of):  <b>ss.</b> Due to (or as a consequence 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28107

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Mendelson, Saundra  
Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August Day 31 Year 2011		3. Time of Death 8:40 PM
Saundra M. Mendelson				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Greater Baltimore Medical Center				
5. Social Security Number 214-38-5895		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/16/1941
				9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent 10a. State MD		10b. County BALTIMORE		10c. City, Town or Location REISTERSTOWN
				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 2311 CRESTNOLL ROAD		10f. Zip Code 21136		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry MAISH'S AUTO SERVICE
17. Father's Name (First, Middle, Last) WILLIAM BUCY		18. Mother's Name (First, Middle, Maiden Surname) MARY SHIFLET		
19a. Informant's Name/Relationship (Type, Print) BRIAN MENDELSON/HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 CRESTNOLL ROAD, REISTERSTOWN, MD 21136		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM		Date 09/02/2011
21. Signature of Funeral Service Licensee <i>Michael Bruger</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208		20c. Location - City or Town, State REISTERSTOWN, MD
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Metastatic Breast Cancer		Approximate Interval Between Onset and Death 3 1/2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0056919		28f. Location (Street and Number or Rural Route Number, City or Town, State) 6569 N. Charles St. Towson, MD 21204 / Robert Donegan MD
29b. Signature and title of certifier <i>Robert Donegan Oncologist</i>		29d. Date signed (Month, Day, Year) 09/01/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. Charles St. Towson, MD 21204 / Robert Donegan MD		31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature <i>James J. Farley</i>

ORIGINAL

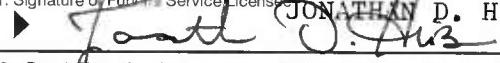
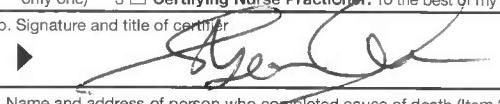
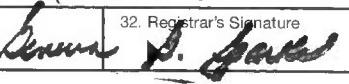
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28108

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last) <b>MARCELLA MITCHELL</b>				2. Date of Death Month <b>August</b> Day <b>31</b> Year <b>2011</b>		3. Time of Death <b>11:30pm</b>	
		4a. Facility Name (if not institution, give street and number) <b>SUMMIT PARK HEALTH &amp; REHAB CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director		5. Social Security Number <b>220-20-9202</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months    Days    Hours    Min.	8. Date of Birth (Month, Day, Year) <b>3-15-1923</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD.</b> 10b. County <b>BALTIMORE</b>				10c. City, Town or Location <b>WOODLAWN</b>			
		10e. Street and Number <b>2121 WINDSOR GARDEN LANE APT D145</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>-2-</b>		16b. Kind of Business Industry <b>SELF EMPLOYED</b>		16c. Kind of Business Industry <b>REAL ESTATE</b>	
		17. Father's Name (First, Middle, Last) <b>FRANK JOHNSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>NANNIE THAXTON</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>BARBARA JOHNSON (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8014 MANSION HOUSE CROSSING PASADENA, MARYLAND 21122</b>			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL</b>		Date <b>9-9-2011</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A.</b> <b>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>ONE MONTH</b>			
		<p>a. Due to (or as a consequence of): <b>UREMIA</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
						29c. License number <b>D0061765</b>		29d. Date signed (Month, Day, Year) <b>9-1-2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EBENEZER GUAINO 3350 WILCENS AVE #307 BALT.</b>				22129			
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

*file backs*

Physician/  
Medical Examiner

*Funeral  
Director*

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

## Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore / Department of Health and Mental Hygiene  
Certificate of Death

2011 28109

Reg. No.

1. Ann		2. Date of Death Month Day Year August 25, 2011		3. Time of Death 0303 hrs
Number)		4b. City, Town, or Location of Death Halethorpe		4c. County of Death Baltimore County
7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) June, 22, 1921
10a. State MD		10b. County Baltimore		9. Birthplace (State or Foreign Country) Maryland
10e. Street and Number 2200 Alletta Avenue		10f. Zip Code 21227		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Cook		16b. Kind of Business/Industry Education
17. Father's Name (First, Middle, Last) Norman G. Reinhardt			18. Mother's Name (First, Middle, Maiden Surname) Anna Delmar Connelly	
19a. Informant's Name/Relationship (Type, Print) Robert P McCann Jr.-Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Alletta Avenue Lansdowne Maryland 21227		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Alton C. Knous</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem Park		Date Sept. 1, 2011
21. Signature of Funeral Service Licensee <i>Alton C. Knous</i>		20c. Location - City or Town, State Elkridge Maryland		
22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road, Lansdowne Maryland 21227				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Smoke Inhalation and Thermal Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. <input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g927 5-10-12 sm 27, 28d, e per me g961 3-21-15 vt				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>fd 8-25-11</b>	28b. Time of Injury <b>fd 0300 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred <b>subject involved in housefire unknown</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Townhouse/Rowhouse Residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2200 Alletta Ave. Halethorpe, MD.</b>		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Theodore M. King, Jr., MD.</i>		
29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 25, 2011		
30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		32. Registrar's Signature <i>Susan J. Parker</i>		
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>				

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28110

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1641 hrs
<b>Stephen John McCruden</b>	August 27, 2011	

4a. Facility Name (if not institution, give street and number) <b>Peninsula Regional Medical Center</b>	4b. City, Town, or Location of Death <b>Salisbury</b>	4c. County of Death <b>Wicomico</b>
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**Funeral Director**

5. Social Security Number <b>213-06-0179</b>	6. Sex <b>1 X M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>35 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>January 21, 1976</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
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10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Nottingham</b>	10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>
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10e. Street and Number <b>3432 Moultrie Place</b>	10f. Zip Code <b>21236</b>	10g. Citizen of What Country? <b>United States</b>
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11. Marital Status <b>1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 X No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 X No specify: White</b>	14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
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15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Welder</b>	16b. Kind of Business/Industry <b>Construction</b>
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17. Father's Name (First, Middle, Last) <b>Stephen Ralph McCruden</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Paula Morgan</b>
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19a. Informant's Name/Relationship (Type, Print) <b>Paula M. Dansker/Mother</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 332, Basye, Virginia 22810</b>
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20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>West Arundel Crematory</b>	Date <b>September 4, 2011</b>	20c. Location - City or Town, State <b>Odenton, Maryland</b>
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21. Signature of Funeral Service Licensee <b>Will E. Brown Jr.</b>	22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Pneumonia complicated by cocaine and oxycodone use</b>	Approximate Interval Between Onset and Death
--	--

Due to (or as a consequence of):

b. Due to (or as a consequence of):	
--	--

c. Due to (or as a consequence of):	
--	--

d. Due to (or as a consequence of):	
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<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g920 10-7-11 sm	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiomegaly</b>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:	26. Place of Death (Check only one) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
---	---	---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Leanne S. Parker</b>
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**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

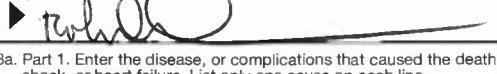
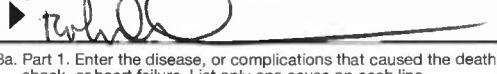
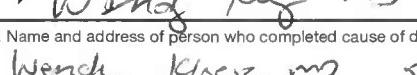
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No.

2011 28111

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Ethel Mae McMillian</b>						2. Date of Death Month Day Year <b>September 2, 2011</b>		3. Time of Death <b>7:40A.M.</b>		
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>1940 Sidnee Drive</b>			4b. City, Town, or Location of Death <b>Edgewood</b>			4c. County of Death <b>Harford</b>				
To Be Completed by Funeral Director		5. Social Security Number <b>225-03-3008</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar 30, 1919</b>	W/M/B/I/P/C/S/E/F/G Birthplace (State or Foreign Country) <b>Virginia</b>			
Usual Residence of Decedent		10a. State <b>Md.</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Edgewood</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1940 Sidnee Drive</b>					10f. Zip Code <b>21040</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status  <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:				
15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>College (1-4 or 5+) Factory Worker</b>			16b. Kind of Business Industry  <b>Jean Factory</b>							
17. Father's Name (First, Middle, Last) <b>Samuel Everett Ward</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Myrtle Lewis</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mary F. Ward/Sister-in-Law</b>		19b. Mailing Address/Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1940 Sidnee Drive Edgewood, Maryland 21040</b>										
20a. Method of Disposition  <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem Gar</b>			20c. Location - City or Town, State <b>September 6, 2011 Middle River, Md.</b>							
21. Signature of Funeral Service Licensee  					22. Name and Address of Facility <b>Kaczorowski Funeral Home, P.A.</b>			23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <b>Dehydration</b> Due to (or as a consequence of):  <b>Anemia</b> Due to (or as a consequence of):  <b>Pneumonia</b> Due to (or as a consequence of):  d.			Approximate Interval Between Onset and Death <b>Weeks</b>	
23a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  								23e. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)  <b>28b. Time of injury M</b> 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier  					29c. License number  <b>D31295</b>			29d. Date signed (Month, Day, Year)  <b>9/3/10</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Wendy Kaczorowski 5701 Kenwood Ave Baltimore MD 21209</b>												
31. Date filed (Month, Day, Year)  <b>Sep 06 2011</b>		32. Registrar's Signature  										
State Registrar												

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

IMH 17 Rev 7/2009

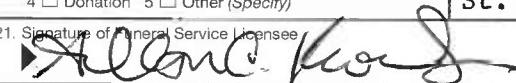
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28112

1- For State Registrar		Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death			
		Linda Nunnally						Month Day Year		August 28 2011 1:10 A M			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death		4c. County of Death			
		Seasons Hospice						Randallstown		Baltimore			
Funeral Director		5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
		215-58-2812		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		62 Yrs.		Months	Days	Hours	Min.	Sept. 22, 1948 Maryland	
To Be Completed by Funeral Director		10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits					
		MD		N/A		Baltimore		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number		10f. Zip Code						10g. Citizen of What Country?			
		2523 James Street		21230						USA			
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.			
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				Specify: White			
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry					
		Elementary/Secondary (0-12) 12		Beautician				Cosmetology					
		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)									
Everett Wilbert Ellis		Roberta Agnus Kellum											
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Stancee Hansen-Daughter		2523 James Street Baltimore Maryland 21230											
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		St. Marys Cemetery		Sept. 2, 2011		Baltimore, Maryland							
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						Ambrose Funeral Home of Lansdowne					
		2719 Hammonds Ferry Road Lansdowne Maryland 21227											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death					
a. Due to (or as a consequence of):  <i>Chronic Obstructive Pulmonary Disease</i>													
b. Due to (or as a consequence of):													
c. Due to (or as a consequence of):													
d. Due to (or as a consequence of):													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Describe how injury occurred						24c. Describe how injury occurred					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Inpatient Hospice</i>						24d. Describe how injury occurred					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 						29c. License number		29d. Date signed (Month, Day, Year)			
								D0053337		August 28, 2011			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
Dorothy Seay MD 2835 Smith Avenue Ste 203 Baltimore, MD 21209													
31. Date filed (Month, Day, Year)		32. Registrar's Signature											
SEP 06 2011													

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 28113

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charles Nixon</i>						2. Date of Death Month <u>8</u> Day <u>30</u> Year <u>2011</u>	3. Time of Death <u>7:55P M</u>	
	4a. Facility Name (if not institution, give street and number) <i>6911 Alter Street</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>245-74-4902</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>63 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>8/18/948</i>	9. Birthplace (State or Foreign Country) <i>N/C</i>		
To Be Completed by Funeral Director	10a. State <u>MD</u> 10b. County <u>Baltimore</u> 10c. City, Town or Location <u>Baltimore</u>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>6911 Alter Street</i>			10f. Zip Code <i>21207</i>			10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>5+</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>College</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Pharmacist</i>			16b. Kind of Business Industry <i>Health Care</i>		
	17. Father's Name (First, Middle, Last) <i>Charles James Nixon</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Erma Lee Joyner</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Charles Nixon II/Son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5505 Sagra Road, Ba Ho. MD 21239</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Moreland</i>			20b. Place of Disposition (Name of Cemetery, crematory or other place) <i>Moreland</i>			Date <u>9-7-2011</u>	20c. Location - City or Town, State <i>Baltimore MD</i>	
	21. Signature of Funeral Service Licensee <i>Vaughn C. Kline</i>			22. Name and Address of Facility <i>Vaughn C. Greene Funeral Service</i> <i>8728 Liberty Road Randallstown, MD 21133</i>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Myocardial Infarction</i>								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): <i>Diabetes</i></p> <p>b. Due to (or as a consequence of): <i>Hypertension</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obesity</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D 23964</i>			29d. Date signed (Month, Day, Year) <i>9/1/11</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jeffrey Gabor 1838 Greene Tree Rd Baltimore, Md 21208</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>			32. Registrar's Signature <i>Connie J. Gabor</i>			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles E. Nixon Sr.

DOB 8-30-11 7:55pm

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28114

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>META NO ZSAIC</b>		2. Date of Death Month <b>SEPT</b> Day <b>1ST</b> Year <b>2011</b>		3. Time of Death <b>11 A M</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>AUGSBURG 6811 Campfield</b>		4b. City, Town, or Location of Death <b>BALTIMORE MD 21207</b>		4c. County of Death <b>BALTIMORE CO</b>		
		5. Social Security Number <b>160-26-8262</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93 Yrs.</b>	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <b>06-12-1918</b>	9. Birthplace (State or Foreign Country) <b>PA</b>
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number <b>2108 Mosby Ave</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>8th grade</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Clerk</b>	16b. Kind of Business Industry <b>WT Grant Company</b>				
		17. Father's Name (First, Middle, Last) <b>Edmund Eschrich</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Groebel</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Grand Melinda J. Lepley-Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2108 Mosby Ave, Baltimore, Md 21207</b>				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Grandview</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/6/2011</b>	20c. Location - City or Town, State <b>Johnston, PA</b>	
		21. Signature of Funeral Service Licensee <b>Regina C. Birch</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>PVD</b>		Approximate Interval Between Onset and Death				
		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CHF</b>						
		23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? <b>CRI, dementia</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>R130191</b>				
		29b. Signature and title of certifier <b>Regina C Birch CENP</b>		29d. Date signed (Month, Day, Year) <b>9-1-11</b>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Regina Birch CENP 6811 Campfield Rd Baltimore Md 21207</b>						
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Regina C. Birch</b>				

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

6

No. 2011 28115

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Katherine Nelson</b>						2. Date of Death Month Day Year <b>September 3, 2011</b>	3. Time of Death M <b>1311</b>	
		4a. Facility Name (if not institution, give street and number) <b>Shady Grove Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director		5. Social Security Number <b>269-48-8815</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Nov 30, 1950</b>	9. Birthplace (State or Foreign Country) <b>Connecticut</b>		
		Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number <b>19107 Willow Spring Drive</b>			10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business Industry <b>Healthcare</b>		
		17. Father's Name (First, Middle, Last) <b>George Peter Nelson, Jr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Louise Dodd</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Mary Louise Nelson/mother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3240 Lake Pointe Blvd. #371 Sarasota, FL 34231</b>					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>			Date <b>09/07/11</b>		
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			20c. Location - City or Town, State <b>Woodbine, MD</b>		
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Septic shock</b> Due to (or as a consequence of): <b>respiratory failure</b>								Approximate Interval Between Onset and Death
		b. Secondary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>pneumothorax</b> Due to (or as a consequence of): <b>pneumonia</b>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		29b. Signature and title of certifier 		29c. License number <b>71323</b>		29d. Date signed (Month, Day, Year) <b>9/3/11</b>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Usha Venigalla MD 9901 Medical Ct Dr Rockville, MD 20850</b>								
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 						

**Division of Vital Records, P.O. Box 68760**

- To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
- To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 6876

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28116

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Bueford L. Newton

2. Date of Death

Month

Day

Year

AUGUST 27, 2011

10:20 PM

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

St. Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-30-3903

6. Sex

 M F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

9/24/1931

3. Time of Death

10:20 PM

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland

Baltimore

Towson

10d. Inside City Limits

 Yes  No

10e. Street and Number

1041 Windsford Road

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes 2  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Seconday (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Salesman / Route Sales

16b. Kind of Business Industry

Bakery

17. Father's Name (First, Middle, Last)

Everett Newton

18. Mother's Name (First, Middle, Maiden Surname)

Matie Leo Marah

19a. Informant's Name/Relationship (Type, Print)

Joseph Newton / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6910 Misty Lake Court Fort Myers, FL 33908

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Cem.

Date

9/2/2011

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

► [Signature]

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):  
Stock

Approximate Interval Between Onset and Death

4 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
CARDIAC ARRHYTHMIA

4 HRS

c. Due to (or as a consequence of):  
CARDIOMYOPATHY

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown24a. Was an autopsy performed?  
1  Yes 2  No24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural  
2  Accident  
3  Suicide  
4  Homicide5  Pending Investigation  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
M1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► V. J. B. Borker

29c. License number

D65045

29d. Date signed (Month, Day, Year)

08/28/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREETAM SOLEPALEM, M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Lena J. Borker

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 28117

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

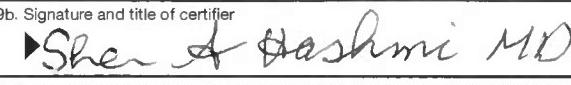
Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>WALTER MARTIN NICKEL</b>		2. Date of Death Month Day Year <b>09 01 2011</b>		3. Time of Death M <b>3 15A M</b>
4a. Facility Name (if not institution, give street and number) <b>LOCH RAVEN COMMUNITY LIVING CENTER BALTIMORE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>212-46-9841</b>		6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>66 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>3/5/1945</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Inside City Limits <b>1 □ Yes 2 X No</b>		
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Cockeysville</b>	
10e. Street and Number <b>11100 Pool Road</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4 Field Engineer</b>	16b. Kind of Business Industry <b>Xerox</b>	
17. Father's Name (First, Middle, Last) <b>Albert G. Nickel</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jeannette Weibley</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Marie E. Nickel / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11100 Pool Road Cockeysville, Maryland 21030</b>		
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Serv. Corp.</b>	Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>Towson, Maryland</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc.</b> <b>1050 York Road Towson, Maryland 21204</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <b>PROGRESSIVE SUPRA NUCLEAR PARKINSON</b> Due to (or as a consequence of):				
b. <b>HYPERTENSION</b> Due to (or as a consequence of):				
c. <b>DIABETES MELLITUS TYPE 2</b> Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown		
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)		
27. Manner of Death X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 □ Yes 2 □ No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>024648</b>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>09-01-2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHER A HASHMI 3900 LOCH RAVEN BLVD BALTIMORE MD 21218</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 		

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

1- For State Registrar

Reg. No.

2011 28118

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0432 hrs
TRACEY SARA OFFUTT	September 1, 2011	

4a. Facility Name (if not institution, give street and number) <b>329 Snowfall Way</b>	4b. City, Town, or Location of Death <b>Westminster</b>	4c. County of Death <b>Carroll</b>
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5. Social Security Number <b>065-66-9262</b>	6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>33</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>07/15/1978</b>	9. Birthplace (State or Foreign Country) <b>NY</b>

10a. State <b>MD</b>	10b. County <b>CARROLL</b>	10c. City, Town or Location <b>WESTMINSTER</b>	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number <b>329 SNOWFALL WAY</b>	10f. Zip Code <b>21157</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: <b>WHITE</b>	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b>	16b. Kind of Business/Industry <b>NURSE</b>
--	--	--

17. Father's Name (First, Middle, Last) <b>LEONARD MILLER</b>	18 Mother's Name (First, Middle, Maiden Surname) <b>SANDRA WEISS</b>
--	---

19a. Informant's Name/Relationship (Type, Print) <b>JASON G. OFFUTT/HUSBAND</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>329 SNOWFALL WAY, WESTMINSTER, MD 21157</b>
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Seton M. Cutler</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CARROLL CREMATION</b>	Date <b>09/04/2011</b>	20c. Location - City or Town, State <b>HAMPSTEAD, MD</b>
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21. Signature of Funeral Service Licensee <i>Seton M. Cutler</i>	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>
---	--

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician /Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <b>Probable Choking</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to (or as a consequence of):	
---	--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
--	--	--

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED 4a per me g920 10-12-11 vt 23a, 27, 28a-f per me g921 11-2-11 vt	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>fd 9-1-11</b>	28b. Time of Injury <b>fd 4:21am</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>probable choking on food bolus</b>
---	--	---	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found at residence</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>329 Snowfall Way Westminster, Md.</b>
---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
---

29b. Signature and title of certifier <i>D. M. Vincenti</i>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 1, 2011</b>
--	--	---

30. Name and address of person who completed cause of death (Item 23a) <b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
--

31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <i>Debra J. Parker</i>
---	---

**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Items 20a, 22 per fh g919 9-6-11 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28119

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary Ochs</i>							2. Date of Death Month <input checked="" type="checkbox"/> August Day <input checked="" type="checkbox"/> 17 Year <input checked="" type="checkbox"/> 2011	3. Time of Death <input checked="" type="checkbox"/> 12:25 AM
	4a. Facility Name (if not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>Randallstown</b>			4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-54-4326</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>Nov 25, 1948</b>	9. Birthplace (State or Foreign Country) <input checked="" type="checkbox"/> unk		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b>				10c. City, Town or Location <b>Brooklyn</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>3808 8th St.</b>			10f. Zip Code <b>21225</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. <input checked="" type="checkbox"/> unk Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation <input checked="" type="checkbox"/> unk (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry <input checked="" type="checkbox"/> unk		
17. Father's Name (First, Middle, Last) <input checked="" type="checkbox"/> unk				18. Mother's Name (First, Middle, Maiden Surname) <input checked="" type="checkbox"/> unk					
19a. Informant's Name/Relationship (Type, Print) <b>Lisa Leto - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <input checked="" type="checkbox"/> unk <b>3809 8th Street Brooklyn, MD 21225</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crem</b>			Date <b>9-1-2011</b>	20c. Location - City or Town, State <b>Glen Burnie MD</b>		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>			22. Name and Address of Facility <input checked="" type="checkbox"/> unk <b>State Anatomy Board Simplicity Cremation &amp; Funeral Serv Thomas Allen 655 W. Baltimore St., Baltimore, MD 21201 PA. Hanover, Md. 21076</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>End-Stage COPD</b>								Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): <b>End-Stage COPD</b>									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> in-patient hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D00S7465</b>						29d. Date signed (Month, Day, Year) <b>8/17/11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. S. Rajapakse, M.D. 2835 S. Main An 5703 Baltimore MD 21209.</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28120

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Miguel Angel Perez</b>			2. Date of Death Month Day Year <b>Sept. 2, 2011</b>			3. Time of Death Month Day Year <b>0840 M</b>			
4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
5. Social Security Number <b>216-64-0423</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>66 Yrs.</b>		If Under 1 Year Months Days Hours Min.		8. Date of Birth Month Day Year <b>4/14/1945</b>	
9. Birthplace (State or Foreign Country) <b>Guatemala</b>									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	
10e. Street and Number <b>2100 Belvedere Blvd. Apt. 1</b>			10f. Zip Code <b>20902</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Mail Clerk</b>		16b. Kind of Business Industry <b>Mail</b>					
17. Father's Name (First, Middle, Last) <b>Ramon Perez</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Albertina Moriera</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Wife Beatriz Custodio Perez/</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2100 Belvedere Blvd. Apt. 1 Silver Spring, Md 20902</b>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Chesapeake Crem.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>		Date <b>9/06/2011</b>	20c. Location - City or Town, State <b>Beltsville, Md</b>			
21. Signature of Funeral Service Licensed			22. Name and Address of Funeral Service <b>PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md 20910</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>anoxic encephalopathy, Type II Diabetes</b>		23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
23g. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mellitus, Renal insufficiency</b>		23h. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23i. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Bethesda, Md</b>			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D 0065485</b>		29d. Date signed (Month, Day, Year) <b>09/02/2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Barbara Supanich MD 1500 Forest Glen Rd Silver Spring, Md 20910</b>							
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Barbara Supanich</b>					

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

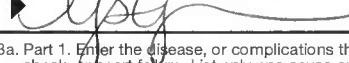
State of Maryland / Department of Health and Mental Hygiene

2011 2812

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>ELNORA POWELL</b>				2. Date of Death Month <b>AUGUST</b> Day <b>10</b> Year <b>2011</b>	3. Time of Death <b>9:00A M</b>		
	4a. Facility Name (if not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>	
<b>Funeral Director</b>	5. Social Security Number <b>127-26 5569</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>NOV. 15 1921</b>	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>	
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b> 10b. County <b>PRINCE GEORGE'S</b> 10c. City, Town or Location <b>CLINTON</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>9604 DALMATIA DRIVE</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPER</b>			16b. Kind of Business Industry <b>PRIVATE</b>	
	17. Father's Name (First, Middle, Last) <b>ALEX POWELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SALLY DAWTIN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GLENN POWELL/SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9604 DALMATIA DRIVE CLINTON, MARYLAND 20735</b>				
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RIVERDALE CREMATORIUM</b>		Date <b>8/12/2011</b>	20c. Location - City or Town, State <b>RIVERDALE, MARYLAND</b>		
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME, INC.</b> <b>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>ACUTE MYOCARDIAL INFARCTION</b> <b>DAYS</b> <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>YEARS</b>				Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>D 18545</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 10, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. WISOWSKY 6701 12070 OLD LINE CENTER WALNUT MD, 20602</b>							
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28122

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susie Beatrice Peace</b>					2. Date of Death Month <b>8</b> Day <b>29</b> Year <b>2011</b>	3. Time of Death <b>1643 M</b>	
	4a. Facility Name (if not institution, give street and number) <b>Washington Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>245-54-6512</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months <b>03</b> Days <b>26</b>	If Under 24 Hrs. Hours <b>16</b> Min. <b>43</b>	8. Date of Birth (Month, Day, Year) <b>03/26/1938</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>DC</b> 10b. County			10c. City, Town or Location <b>Washington</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>711 Longfellow Street, N.W.</b>			10f. Zip Code <b>20011</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business Industry <b>Self</b>		
	17. Father's Name (First, Middle, Last) <b>Stanley Cousin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Georgianna Henderson</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Peace Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9603 49th Place; College Park, Maryland 20740</b>					
Physician/ Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Chesapeake Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>09/02/2011</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Freeman</b>		22. Name and Address of Facility <b>Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. <i>Anoxic encephalopathy due to cardiac arrest</i> Due to (or as a consequence of): <i>one day</i></p> <p>b. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): <i>one day</i></p> <p>c. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): <i>one day</i></p> <p>d. _____</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>M Karim MD</b>		29c. License number <b>D-18895</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOBARAK KARIM 7610 CARROLL AVE, STE 340, TAKOMA PARK, MD 20912</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Laura L. Parker</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28123

Physician  
/Medical  
Examiner1- For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)			2. Date of Death			
<b>ROBERT PHILLIPS</b>			Month	Day	Year	3. Time of Death
			AUGUST 30 2011 (0647 AM)			
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			
<b>Johns Hopkins Bayview Medical Center</b>			<b>Baltimore</b>			
4c. County of Death						
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)
<b>578-34-8775</b>		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<b>81 Yrs.</b>	Month	Day	<b>D.C.</b>
10a. State		10b. County	10c. City, Town or Location			
<b>MD</b>		<b>Baltimore</b>	<b>Dundalk</b>			
10d. Inside City Limits						
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						

Baltimore, Maryland 21215-0036  
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

## To Be Completed by Funeral Director

10e. Street and Number		10f. Zip-Code	10g. Citizen of What Country?
<b>209 Rivervale Avenue</b>		<b>21222</b>	<b>USA</b>
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREA</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>MANAGER</b>	16b. Kind of Business/Industry <b>Grocery</b>	
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Rosemary Cabbiness-Friend</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6920 Delvalle Place, Dundalk, MD 21222</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Bayview Cemetery 8-31-11</b>	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee <b>[Signature]</b>	22. Name and Address of Facility <b>Bradley-Ashton Funeral Home, PA, 2134 W. New Spring Road 21222</b>		

Division of Vital Records, P.O. Box 68760, Baltimore, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{ a. <b>Respiratory Failure</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. _____ d. _____		<b>2 hours</b> <b>2 weeks</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Sara Damewood, MD</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sara Damewood, MD</b>		29c. License number <b>D70659</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2011</b>
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Susan J. Parker</b>		
4940 Eastern Avenue, Baltimore, MD, 21224				

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28124

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Masio

Pearson

2. Date of Death

Month 08

Day 27

Year 2011

3. Time of Death  
11:35a M

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

251-08-0649

6. Sex

M

F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Month 11

Day 24

Year 56

9. Birthplace (State or Foreign Country)

SC

To Be Completed by Funeral Director  
Usual Residence of Decedent  
10a. State MD  
10b. County NA  
10c. City, Town or Location Baltimore  
10e. Street and Number 2914 Edgecombe Circle South  
10f. Zip Code 21215  
10g. Citizen of What Country? U.S.A.  
11. Marital Status  
1  Never Married 2  Married  
3  Widowed 4  Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
1  Yes 2  No  
If Yes, Give Year or Dates.  
15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 11th grade  
College (1-4 or 5+) na  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Mixer  
16b. Kind of Business Industry McCormick Spice Co.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

17. Father's Name (First, Middle, Last)

Richard Pearson

18. Mother's Name (First, Middle, Maiden Surname)

Julia Caldwell

19a. Informant's Name/Relationship (Type, Print)

Willie Pearson-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215

2914 Edgecombe Circle South, Baltimore Md

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

9/6/2011

20c. Location - City or Town, State

Woodlawn, Md

21. Signature of Funeral Service Licensee

► Donald C. Omigwa

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

{

a. myocarditis factus.  
Due to (or as a consequence of):

b. Hypertension  
Due to (or as a consequence of):

c. Chronic renal insufficiency  
Due to (or as a consequence of):

d. Hyper Cholesterolemia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

26. Place of Death (Check only one)

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 3  Suicide 4  Homicide  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► N. Swanson

29c. License number

D0054836

29d. Date signed (Month, Day, Year)

8.31.11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NALAYINI SIVARAMAN

4340 Park Heights Ave  
Balt MD 21215

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

► S. Pearson

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28125  
Reg. No.1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Funeral  
Director

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 9:50 p M			
Josephine Parks		8/27/2011							
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Gilchrist Hospice		Towson				Baltimore			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
212-36-5713		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	69 Yrs.				9/14/1941	MD	
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
MD	NATLIMORE	Baltimore							
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?			
1710 Homestead Street		21218				USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced									
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 10th		College (1-4 or 5+) N/A				Spot Welder American Cup Co.			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
Joseph Jones		Beatrice Gilbert							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Deirde Pernal-Daughter		2431 W. Lexington St. Balto. MD 21223							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
		King Memorial Pk.		9/3/2011		Randallstown, MD			
21. Signature of Funeral Service Licensee <i>► 13n Cljt</i>		22. Name and Address of Facility				March F/H 1101 E. North Ave. Baltimore, MD 21202			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>METASTATIC RENAL CELL CARCINOMA</i>				Approximate Interval Between Onset and Death			
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>► Syed Shabas</i>		29c. License number <i>D72139</i>				29d. Date signed (Month, Day, Year) <i>8-28-2011</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
6701 N CHARLES STREET SUITE 4105 BALTIMORE MD 21204.									
31. Date filed (Month, Day, Year) <i>SEP 06 2011</i>		32. Registrar's Signature <i>Anna J. Parks</i>							

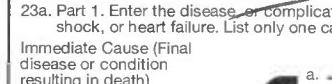
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #26 Per PHY G919 9/06/2011 IH  
 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28126

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gertrude Paris</i>							2. Date of Death Month September Day 1 Year 2011	3. Time of Death 11:55 P M
	4a. Facility Name (if not institution, give street and number) <b>MILFORD MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>064-14-6143</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>10/15/1919</b>	9. Birthplace (State or Foreign Country) <b>POLAND</b>
	Usual Residence of Decedent <b>MD BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>130 SLADE AVENUE, #314</b>				10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>ISAAC M BERRENSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BERTHA BRZOZA</b>					
19a. Informant's Name/Relationship (Type, Print) <b>IRA MARK PARIS/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>160 WEST END AVENUE, NEW YORK, NY 10023</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOSES MONTEFIORE WOODMOOR HEBREW CEM.</b>			Date <b>09/02/2011</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Atherosclerotic Cardiovascular Disease</i>								Approximate Interval Between Onset and Death
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
Medical Certificate: To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Inpatient hospice</i>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>N.S. Rajapakse, M.D.</i>					
				29c. License number <b>D0057465</b>			29d. Date signed (Month, Day, Year) <b>9/2/11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N.S. Rajapakse, M.D. 2835 Smith Av 5203</b>				31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>					
				32. Registrar's Signature <i>Laura B. Davis</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

W

State Registrar	33. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
	34. Registrar's Signature <i>Laura B. Davis</i>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28127

1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed  
 completed filled in by the funeral director; After this certificate has been signed by the attending physician and  
 within 24 hours after death.

(3)

1. Decedent's Name (First, Middle, Last)

Lenora E. Riley

2. Date of Death  
Month September Day 01 Year 20113. Time of Death  
02:40 PM

4a. Facility Name (if not institution, give street and number)

Peartree Assisted Living

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

216-12-6627

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year  
MonthsIf Under 24 Hrs.  
Days8. Date of Birth  
(Month, Day, Year)

April 20 1921

9. Birthplace (State or Foreign  
Country)

MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

4816 Mountain Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business Industry

M T A

17. Father's Name (First, Middle, Last)

John A. Ellison

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Chairs

19a. Informant's Name/Relationship (Type, Print)

William E. Riley (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

548 Grays Creek Road, Pasadena, MD 21122

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Church Cem

Date

Sept. 08

20c. Location - City or Town, State

Pasadena, Maryland

21. Signature of Funeral Service Licensee

► *John A. Riley*

22. Name and Address of Facility

Stallings Funeral Home, P.A.  
3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

5 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify) \_\_\_\_\_  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

26. Place of Death (Check only one)

1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify) *Ajaxed home*

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *John A. Riley*

29c. License number

D20094

29d. Date signed (Month, Day, Year)

09/02/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

► *John A. Riley 1411 Madva Park Drive Glen Burnie MD 21061*

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

*James J. Sparta*State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND. ITEM #10a-f, per FH G945, 11/1/2013, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28128

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

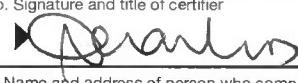
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JACQUES R. RUBIN</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>1</b> , Year <b>2011</b>	3. Time of Death <b>3:06 P M</b>
4a. Facility Name (if not institution, give street and number) <b>GILCHRIST HOSPICE</b>		4b. City, Town, or Location of Death <b>TOWSON</b>	
4c. County of Death <b>BALTIMORE</b>			
5. Social Security Number <b>199-30-6489</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.
8. Usual Residence of Decedent <b>Palm Beach BALTIMORE</b>		If Under 1 Year Months      Days	If Under 24 Hrs. Hours      Min.
9. Birthplace (State or Foreign Country) <b>PA</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2100 S. Ocean Blvd., Apt. 101</b>		10f. Zip Code <b>21208</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE</b>		16b. Kind of Business/Industry <b>BIO TECH INDUSTRY</b>	
17. Father's Name (First, Middle, Last) <b>SAMUEL RUBIN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA ZABLINSKY</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MARLENE RUBIN / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 POMONA EAST, #604 BALTIMORE, MD 21208</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH EL MEM. PARK</b>	Date <b>9/4/2011</b>
20c. Location - City or Town, State <b>RANDALLSTOWN, MD</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic cardiomyopathy, coronary artery disease</b>	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month      Day      Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>September 2 2011</b>	28b. Time of injury <b>M</b>
28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number <b>D58303</b>		29d. Date signed (Month, Day, Year) <b>September 2 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marie J. Morris MD 6701 N Charles St Towson MD</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
32. Registrar's Signature 			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 29d, perpHYS, G919, 9/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28129

1- For State Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

## Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death	
<b>ELIZABETH REICHENBACH</b>		Month	Day Year
4a. Facility Name (if not institution, give street and number)		3. Time of Death	
<b>FUTURECARE CHERRYWOOD</b>		9:15 PM	
4b. City, Town, or Location of Death		4c. County of Death	
<b>REISTERSTOWN</b>		<b>BALTIMORE CO</b>	
5. Social Security Number		6. Sex	
<b>212-36-4663</b>		<input type="checkbox"/> M	<input checked="" type="checkbox"/> F
7. Age (In yrs. last birthday)		If Under 1 Year	
Yrs. <b>73</b>		Months	Days
8. Date of Birth		9. Birthplace (State or Foreign Country)	
(Month, Day, Year) <b>July 24, 1938</b>		<b>MARYLAND</b>	
10a. State		10b. County	
<b>MD</b>		<b>Baltimore</b>	
10c. City, Town or Location		10d. Inside City Limits	
<b>Reisterstown</b>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number		10f. Zip Code	
<b>102 Salony Drive</b>		<b>21136</b>	
10g. Citizen of What Country?		<b>U.S.A.</b>	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		<b>White</b>	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
<b>Elementary/Secondary (0-12) 12</b>		<b>Homemaker</b>	
16b. Kind of Business Industry		<b>Own Home</b>	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
<b>William Howard Miller</b>		<b>Elizabeth Gertrude Temple</b>	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
<b>Sharon D. Levin Daughter</b>		<b>127 Chargeur Road, Reisterstown, MD 21136</b>	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		<b>Sacred Heart of Jesus</b>	
20c. Location - City or Town, State		Date <b>8/31/11</b>	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	
<b>Stephen M Jenkins</b>		<b>11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Maryland 21136</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. <b>Arteriosclerotic Vascular Disease</b> Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>RE8852</b> 29d. Date signed (Month, Day, Year) <b>August 30, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<b>Karen C. Dimmick 2835 Smith Avenue #203 Baltimore, Maryland 21209</b>	
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>James J. Parker</b>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28130

## Certificate of Death

Reg. No.

## 1- For State Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Nicholas Andrew Robinson</b>							2. Date of Death Month Day Year <b>September 1, 2011</b>	3. Time of Death 1435 hrs
	4a. Facility Name (if not institution, give street and number) <b>7906 Darien Drive</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>	
<b>Funeral Director</b>	5. Social Security Number <b>525-89-3272</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>25 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>07-24-1986</b>	9. Birthplace (State or Foreign Country) <b>Germany</b>		
	10a. State <b>MD</b>				10b. County <b>Anne Arundel</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>1455 Georgia Avenue</b>				10f. Zip Code <b>21144</b>			10g. Citizen of What Country? <b>United States</b>	
<b>Physician /Medical Examiner</b>	11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>	14. Race - American Indian, Black, White, etc. <b>Specify: Asian</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Catering</b>			16b. Kind of Business/Industry <b>Food</b>	
<b>Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036</b>	17. Father's Name (First, Middle, Last) <b>Eric Andrew Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jung S. Kim</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>William L. Benton / Step-Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1455 Georgia Avenue Severn, Maryland 21144</b>				
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>W. Arundel Crematory</b>			Date <b>9-10-2011</b>	20c. Location - City or Town, State <b>Odenton, Maryland</b>		
	4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b><i>None</i></b>								
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <b><i>William L. Benton</i></b>				22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Methadone and Alprazolam Intoxication</b>							Approximate Interval Between Onset and Death	
	Due to (or as a consequence of):								
	b. _____ Due to (or as a consequence of):								
	c. _____ Due to (or as a consequence of):								
	d. _____ UNPENDED <input checked="" type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g919 9-26-11 sm								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene					24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>fd 9-1-11</b>		28b. Time of Injury <b>fd 2:30 pm</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Unknown</b>		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify)</b>		Residence			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>7906 Darien Dr. Glen Burnie, Md.</b>	
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>				32. Registrar's Signature <b><i>Leanne J. Parker</i></b>			29d. Date signed (Month, Day, Year) <b>September 2, 2011</b>	
<b>To the Hospital or Attending Physician:</b> The law requires that the death certificate be executed within 24 hours after death. <b>To the Funeral Director:</b> After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. <b>Important:</b> If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		33. License number <b>O.C.M.E.</b>			34. OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28131

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Catherine Riley DOB 02/09/1919  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>8</u> Day <u>29</u> Year <u>2011</u>		3. Time of Death <u>7:45 AM</u>
<u>Catherine Riley</u>				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<u>Oakcrest Care Center</u>		<u>Parkville</u>		<u>Balto.</u>
5. Social Security Number <u>213-05-5536</u>		6. Sex <u>1</u> M <u>2</u> F	7. Age (In yrs. last birthday) <u>92</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
				8. Date of Birth (Month, Day, Year) <u>2/09/1919</u>
				9. Birthplace (State or Foreign Country) <u>Maryland</u>
10a. State <u>Md.</u>		10b. County <u>Balto.</u>	10c. City, Town or Location <u>Parkville</u>	
			10d. Inside City Limits <u>1</u> Yes <u>2</u> No	
10e. Street and Number <u>8820 Walther Blvd. #4413</u>		10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <u>3</u> Widowed		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:	
			14. Race - American Indian, Black, White, etc. <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) <u>9th</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cable Assembler</u>	16b. Kind of Business Industry <u>Western Electric</u>	
17. Father's Name (First, Middle, Last) <u>Bernard Bangert</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Katherine Pfiel</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Michael Riley</u> son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1110 Rye Gate Road Towson, Md. 21286</u>		
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Oaklawn Cemetery</u>	Date <u>9-2-2011</u>	20c. Location - City or Town, State <u>Balto, Md.</u>
21. Signature of Funeral Service Licensee <u>Brian A. Welle</u>		22. Name and Address of Facility <u>Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236</u>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of): <u>myocardial infarction</u></p> <p>b. Due to (or as a consequence of): <u>atherosclerotic coronary artery disease</u></p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <u>1</u> Yes <u>2</u> No <u>9</u> Unknown		23c. If yes, outcome of pregnancy <u>1</u> Live Birth <u>2</u> Fetal death <u>3</u> Ectopic pregnancy <u>4</u> Pregnant at time of death <u>5</u> Other (specify) <u>9</u> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		
		24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		
		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No		
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) <u>(Skilled)</u>		
27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <u>1</u> Yes <u>2</u> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <u>3</u> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Victoria Vanek MD</u>		
		29c. License number <u>D 32381</u>		29d. Date signed (Month, Day, Year) <u>8-29-2011</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>VICTORIA VANEK MD Oakcrest/R6</u>		31. Date filed (Month, Day, Year) <u>SEP 06 2011</u>		
		32. Registrar's Signature <u>Laura J. Farrel</u>		
		33. Date filed (Month, Day, Year) <u>MD 21234</u>		

Certificate of Death

Reg. No.

2011 28132

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death		
	<b>Bertha Verdena Ranson</b>				Month Day Year <b>August 30 2011</b>			1728 AM		
Funeral Director	4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death		
	<b>St. Agnes Hospital</b>				<b>Baltimore</b>					
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
	<b>212-34-4121</b>	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	<b>73</b> Yrs.				<b>04 25 38</b>			<b>MD</b>
To Be Completed by Physician/Medical Examiner	10a. State				10b. County			10c. City, Town or Location		10d. Inside City Limits
	<b>MD</b>				<b>NA</b>			<b>Gwynn Oak</b>		<b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
Medical Certificate: To Be Completed by Physician/Medical Examiner	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
	<b>1208 Wilson Ave</b>				<b>21207</b>			<b>U.S.A.</b>		
Physician/ Medical Examiner	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry		
	<b>Elementary/Seconday (0-12) 12th grade</b>				<b>College (1-4 or 5+) NA</b>			<b>Supervisor Engineer</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
	<b>Joseph Edwards</b>				<b>Vernice Green</b>					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
	<b>Janet Jones-Daughter</b>				<b>1208 Wilson Ave, Gwynn Oak, Md 21207</b>					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State		
	<b>X <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) King Memorial Park</b>				<b>9/10/2011</b>			<b>Woodlawn, Md</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee				22. Name and Address of Facility					
	<b>[Signature]</b>				<b>March F/H West 4300 Wabash Ave, Baltimore, Md 21215</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23c. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		
To Be Completed by Physician/Medical Examiner	23d. Approximate Interval Between Onset and Death				23e. Due to (or as a consequence of):					
	<b>Atherosclerotic cardiovascular disease</b>				<b>Unknown</b>					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23f. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23g. Due to (or as a consequence of):					
Physician/ Medical Examiner	23h. Due to (or as a consequence of):				23i. Due to (or as a consequence of):					
To Be Completed by Physician/Medical Examiner	23j. Due to (or as a consequence of):				23k. Due to (or as a consequence of):					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23l. IF FEMALE:				23m. Date of delivery					
Physician/ Medical Examiner	23n. 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23o. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23p. Date of delivery		
To Be Completed by Physician/Medical Examiner	23q. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23r. Did tobacco use contribute to the cause of death?					
	<b>Asthma COPD CHF</b>				<b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23s. 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one)					
					<b>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>					
Physician/ Medical Examiner	27. Manner of Death				28a. Date of injury (Month, Day, Year)			28b. Time of injury		
	<b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide</b>				<b>M</b>			<b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
To Be Completed by Physician/Medical Examiner	28c. Injury at work?				28d. Describe how injury occurred					
Medical Certificate: To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Physician/ Medical Examiner	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number			29d. Date signed (Month, Day, Year)		
					<b>D0058141</b>			<b>August 30 2011</b>		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				31. Date filed (Month, Day, Year)			32. Registrar's Signature		
	<b>900 S. Caton Avenue Baltimore, MD 21229</b>				<b>SEP 06 2011</b>			<b>[Signature]</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28133

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Rose Ann Resch

2. Date of Death

Month Day Year  
Sep 1, 2011

3. Time of Death

7:35 A.M.

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Brinton Woods Nursing Center

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

220-56-0721

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month, Day, Year

May 20, 1929

9. Birthplace (State or Foreign Country)

MD

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Once,

any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerotic CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death  
7 months

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patrick A. Turner

29c. License number

D20806

29d. Date signed (Month, Day, Year)

9/2/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK A TURNER 114 Business Center Drive Reisterstown, MD 21136

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

James J. Spiegel

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28134

1 - For  
State  
Registrar

**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 2:30 A M
ELIZABETH KATHERINE RAMSBURG	Aug 29, 2011	
4a. Facility Name (if not institution, give street and number) 2896 RT. 97, GLENWOOD, MD 21738	4b. City, Town, or Location of Death GLENWOOD	4c. County of Death Howard

**Funeral  
Director**

5. Social Security Number 216-20-5166	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov 7, 1925	9. Birthplace (State or Foreign Country) NJ
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Usual Residence of Decedent  
10a. State  
MD  
10b. County  
Carroll  
10c. City, Town or Location  
Marriottsville  
10e. Street and Number  
11850 Ramsburg Road  
10f. Zip Code  
21104  
10g. Citizen of What Country?  
U.S.A.  
  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	Bookkeeper	16b. Kind of Business Industry Farm Supplies
17. Father's Name (First, Middle, Last) Edward Turner	18. Mother's Name (First, Middle, Maiden Surname) Lillian Yardley		
19a. Informant's Name/Relationship (Type, Print) Elizabeth Barron	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2896 Rt. 97 Glenwood, MD 21738		

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens	Date Sep 01, 2011	20c. Location - City or Town, State Marriottsville, Maryland
--	---	----------------------	---

21. Signature of Funeral Service Licensee John Miller, Jr. #00535	22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043
--	--

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <u>ALZHEIMERS DISEASE</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 7 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):	
	c. _____ Due to (or as a consequence of):	
	d. _____	

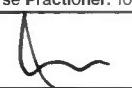
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>daughter's home</u>		
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier 	29c. License number D 56531	29d. Date signed (Month, Day, Year) Aug 29, 2011
--	--------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY LI 8600 SNOWDEN RIVER PKWY #301, COLUMBIA, MD 21045	
31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature 

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

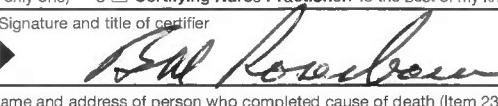
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.  
2011 28135

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sam Evans Reinholtz</b>							2. Date of Death Month Day Year <b>August 30, 2011</b>	3. Time of Death 10:25 a M		
	4a. Facility Name (if not institution, give street and number) <b>3118 Gracefield Rd. #314</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>206-26-5493</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 22, 1932</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>				
To Be Completed by Funeral Director	10a. State <b>MD</b>				10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3118 Gracefield Rd. #314</b>				10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Plumber</b>			16b. Kind of Business Industry <b>Plumbing Contractor</b>			
	17. Father's Name (First, Middle, Last) <b>William Reinholtz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Stonebraker</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Lynda Schweber/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3118 Gracefield Rd. #314 Silver Spring, MD 20904</b>						
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>09/01/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Disease</b>								Approximate Interval Between Onset and Death years		
	a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 		29c. License number <b>D09834</b>		29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Barry N. Rosenbaum, M.D. 3720 Farragut Ave. Kensington, MD 20895</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28136

Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>EUGENE CHARLES ROWE</b>			2. Date of Death Month <b>Aug</b> Day <b>29</b> Year <b>2011</b>		3. Time of Death <b>12:52 PM</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>	
		5. Social Security Number <b>267-36-1176</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months <b>1</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug 22, 1932</b>	9. Birthplace (State or Foreign Country) <b>Florida</b>
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Howard</b>			10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>
		10e. Street and Number <b>6932 Catwing Court</b>			10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <b>1951-55</b></b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 X No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) College (1-4 or 5+) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Research Analyst</b>			16b. Kind of Business Industry <b>Federal Government</b>	
		17. Father's Name (First, Middle, Last) <b>Raymond Isadore Rowe</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Kemper</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Johanna Joslin Rowe/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6932 Catwing Court Columbia, MD 21045</b>			
		20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>	Date <b>09/03/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>	
		21. Signature of Funeral Service Licensee <b>Dewey L. Hecht</b>			22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b>						Approximate Interval Between Onset and Death <b>6 hrs</b>
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Coronary artery disease</b>						
		a. Due to (or as a consequence of): <b>CHRONIC RENAL FAILURE</b>						
		b. Due to (or as a consequence of): <b>HYPERTENSION</b>						
		c. Due to (or as a consequence of): <b>DIMINUTIA</b>						
		d. Due to (or as a consequence of):						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year
		23e. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23f. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23g. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23h. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23i. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
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		23bj. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>HYPERTENSION</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>DIMINUTIA</b>						
		23bj. Did tobacco use contribute to the cause of death? <b>CHRONIC RENAL FAILURE</b>						
		23bj. Did						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 28137

1 - For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		Norma E Rezmer				2. Date of Death Month September Day 1 Year 2011		3. Time of Death 4:45 P M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Jessup				4c. County of Death Howard			
5. Social Security Number 220-38-2127		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day Year) 11/3/1941	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent		10c. City, Town or Location Jessup				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State MD		10b. County Howard		10f. Zip Code 20794				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Norman Clinton Lynch					18. Mother's Name (First, Middle, Maiden Surname) Nellie Galley				
19a. Informant's Name/Relationship (Type, Print) Robbin Rezmer (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8312 Ashwood Road, Jessup MD 20794						

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ardent Cremation		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 9/3/2011	20c. Location - City or Town, State Hanover, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224		

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Leukemia		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
--	--	---	--	--	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
---	--

29b. Signature and title of certifier 		29c. License number DOCS 7465	29d. Date signed (Month, Day, Year) 9/2/11
--	--	----------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse, M.D. 2835 Smith Av S 203 Baltimore MD 21209	
31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature 

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

j5v

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28138

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tasia Reed

2. Date of Death

Month August Day 7 Year 2011

3. Time of Death

6:36 P M

4a. Facility Name (if not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-27-4501

6. Sex

1  M 2  F

7. Age (in yrs. last birthday)

21

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

1/5/1990

9. Birthplace (State or Foreign Country)

MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

4340 Orchard Ridge Rd. Apt. 224

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Seconday (0-12) 12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Cashier

16b. Kind of Business Industry

McDonalds

17. Father's Name (First, Middle, Last)

Ricky D. Reed

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Burroughs

19a. Informant's Name/Relationship (Type, Print)

Tierra Bryant- Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

819 Shipfriend Rd. Baltimore, MD 21220

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

9/2/2011

20c. Location - City or Town, State

Lansdown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H 1101 E. North Ave. Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Kidney cancer

Approximate Interval Between Onset and Death

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

10057465

29d. Date signed (Month, Day, Year)

8/24/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Rajapakse, M.D. 2835 Smith Av S-203 Baltimore MD 21209

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

IV

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28139

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Austin K. Reimer

2. Date of Death

Month Day Year  
August 24 2011

3. Time of Death

16:20 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore city

4c. County of Death

N/A

5. Social Security Number

N/A

6. Sex

1  M2  F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

8/21/2011

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

MD

Baltimore

Owings Mills

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

130 Gentlebrook Rd.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) N/A

College (1-4 or 5+) N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business Industry

N/A

17. Father's Name (First, Middle, Last)

Paul Reimer

18. Mother's Name (First, Middle, Maiden Surname)

Amy Hepler

19a. Informant's Name/Relationship (Type, Print)

Paul Reimer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 Gentlebrook Rd, Owings Mills, Md 21117

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Souls Cemt.

Date

9/1/2011

20c. Location - City or Town, State

West Brandywine, PA

21. Signature of Funeral Service Licensee

► Lynette K. Jones

22. Name and Address of Facility

March F/H 1101 E. North Ave. Baltimore, MD 21202

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extreme Prematurity

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

b. Multiple Congenital Anomalies

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation  
6  Could not be determined

27a. Date of injury (Month, Day, Year)

27b. Time of injury

M

27c. Injury at work?  
1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1  Certifying Physician2  Medical Examiner3  Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

► Jennifer Burnsed

29c. License number

D72735

29d. Date signed (Month, Day, Year)

August 24, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Burnsed

600 N. Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Lynette K. Jones

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

2 ✓

State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28140

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>WON KOO Sung</b>						2. Date of Death Month Day Year <b>August 29, 2011</b>			3. Time of Death 2300 hrs		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>2700 Old St. Johns Lane</b>			4b. City, Town, or Location of Death <b>Ellicott City</b>			4c. County of Death <b>Howard</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>217-13-0321</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>Jan 28, 1963</b>	9. Birthplace (State or Foreign Country) <b>Korea</b>			
To Be Completed by Physician/Medical Examiner		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Howard</b> 10c. City, Town or Location <b>Ellicott City</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>2700 Old St Johns Lane</b>			10f. Zip Code <b>21042</b>			10g. Citizen of What Country? <b>USA</b>					
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>Asian</b>			14. Race - American Indian, Black, White, etc.						
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	College (1-4 or 5+) <b>4</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Contractor</b>			16b. Kind of Business/Industry <b>Construction</b>						
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Moon Yong Sung</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Sang Rye Sung</b>								
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>WON Ito Sung</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13908 Bergenfield Dr. Potomac MD</b>								
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>CrestHawk</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CrestHawk</b>	Date <b>9/16/2011</b>	20c. Location - City or Town, State <b>Marriottsville, MD</b>								
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>John Doe</b>	22. Name and Address of Facility <b>Howell Funeral Home 10220 Guilford Rd., Jessup, MD 20794</b>										
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carbon Monoxide Intoxication Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):											
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):											
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):											
To Be Completed by Physician/Medical Examiner		<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED											
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) <b>9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner								23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	26. Place of Death (Check only one)									
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>FOUND: Aug 29, 2011</b>	28b. Time of Injury <b>FOUND: 2245 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Subject inhaled fumes from a generator</b>							
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Single Family Home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2700 Old St. Johns Lane, Ellicott City, MD</b>					
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <b>John Doe</b>						29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 30, 2011</b>		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>											
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature <b>John Doe</b>								



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28142

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NED ALEXANDER SNEAD</b>				2. Date of Death Month Day Year <b>August 30 2011</b>	3. Time of Death 7:15 p M		
	4a. Facility Name (if not institution, give street and number) <b>715 N FULTON AVENUE APT 1</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>220-30-0382</b>		6. Sex <b>1 XXM 2 □ F</b>	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr. 11 1931</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent 10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>715 N FULTON AVENUE APT 1</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry <b>GENERAL MAINTENANCE</b>		16c. Kind of Business Industry <b>HOUSING AUTHORITY</b>	
	17. Father's Name (First, Middle, Last) <b>DAVID SNEAD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA EPPERSON</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>RODNEY SNEAD/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 N. Fulton Ave., Apt 1, Baltimore, Md. 21217</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		Date <b>09/07/11</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		
	21. Signature of Funeral Service Director 		22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME, P.A. 1206 W NORTH AVENUE, BALTIMORE, MD., 21217</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death			
	a. <i>Esophageal CA</i> Due to (or as a consequence of):							
	b. _____ Due to (or as a consequence of):							
	c. _____ Due to (or as a consequence of):							
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>D0064597</b>		29d. Date signed (Month, Day, Year) <b>9-6-2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert L. Rice, MD 23 Crossroads Dr. Ste 310 Owings Mills, MD 21117</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

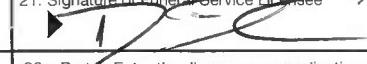
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28143

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MILDRED W. SINDLER</b>						2. Date of Death Month <b>SEPTEMBER</b> Day <b>02</b> Year <b>2011</b>	3. Time of Death <b>07:42P M</b>		
	4a. Facility Name (if not institution, give street and number) <b>1 GRISTMILL COURT, #608</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>	4c. County of Death <b>BALTIMORE</b>		
<b>Funeral Director</b>	5. Social Security Number <b>422-22-6151</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>11/27/1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1 GRISTMILL COURT, #608</b>		10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>4</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>TEACHER</b>			<b>EDUCATION</b>		
	17. Father's Name (First, Middle, Last) <b>JULIUS WEISBERG</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DORA SCHREIBER</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ARNOLD SINDLER/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3523 BARTON OAKS ROAD, BALTIMORE, MD 21208</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>CHIZUK AMUNO</b>			20b. Place of Disposition (Name of Cemetery or Cemetery Unit/Plot) <b>CHIZUK AMUNO</b>		Date <b>09/04/2011</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>						
<b>Physician/ Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Cardiovascular Disease</b>								Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier  <b>M.D.</b>								29c. License number <b>DO 071287</b>	29d. Date signed (Month, Day, Year) <b>9-3-11</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shahreen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>									
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28144

**1-** For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Louis Anthony Spera, Sr.</b>				2. Date of Death Month Day Year <b>August 28, 2011</b>	3. Time of Death 10:25 P M			
	4a. Facility Name (if not institution, give street and number) <b>12B Jefferson Avenue</b>		4b. City, Town, or Location of Death <b>Cockeysville</b>		4c. County of Death <b>Baltimore</b>				
<b>Funeral Director</b>	5. Social Security Number <b>213-20-0040</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Nov 7, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent <b>Maryland Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>		
	10e. Street and Number <b>12B Jefferson Avenue</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>				
<b>Physician/ Medical Examiner</b>	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1944-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 05</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business Industry <b>Body &amp; Fender Repair</b>				
17. Father's Name (First, Middle, Last) <b>Roco Spera</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mamie Machie</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Martha Frances Spera/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12B Jefferson Avenue, Cockeysville, MD 21030</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Dulaney Valley Memorial Gardens</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Timonium, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>			22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093</b>						
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) <b>Hyper tension</b>						Approximate Interval Between Onset and Death <b>3 years</b>		
	b. Due to (or as a consequence of): <b>Anemia</b>						Approximate Interval Between Onset and Death <b>3 years</b>		
c. Due to (or as a consequence of): <b>O.A.</b>		d. Due to (or as a consequence of):			<b>3 years</b>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <b>Natural</b> <input type="checkbox"/> Pending Investigation <b>Accident</b> <input type="checkbox"/> Could not be determined <b>Suicide</b> <input type="checkbox"/> Determined <b>Homicide</b> <input type="checkbox"/>		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Ayman Akkad, M.D.</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ayman Akkad, M.D. 1734 York Road, Lutherville, MD 21093</b>				29c. License number <b>842736</b>		29d. Date signed (Month, Day, Year) <b>8-31-1</b>			
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature <b>Leanne J. Spera</b>						

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

*f-21*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28145

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Dorothy G. Sargent</b>		2. Date of Death Month <b>Sept.</b> Day <b>1</b> Year <b>2011</b>	3. Time of Death <b>1:02 A M</b>
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>3700 Shuger Hill Road</b>		4b. City, Town, or Location of Death <b>Pikesville</b>	
		4c. County of Death <b>Baltimore</b>		4d. Birthplace (State or Foreign Country) <b>New York</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>155-26-1551</b>		6. Sex <b>M</b>	7. Age (in yrs. last birthday) <b>102</b> Yrs.
				If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
				8. Date of Birth (Month, Day, Year) <b>July 15, 1909</b>	
		9. Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	
		10c. City, Town or Location <b>Pikesville</b>		10d. Inside City Limits <b>Yes</b>	
		10e. Street and Number <b>3700 Shuger Hill Road</b>		10f. Zip Code <b>21208</b>	10g. Citizen of What Country? <b>USA</b>
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>	
		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bank Director/Management</b>		16b. Kind of Business Industry <b>Banking</b>	
		17. Father's Name (First, Middle, Last) <b>Hans Engebretsen</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Cecelia Steensen</b>	
		19a. Informant's Name/Relationship (Type, Print) <b>Bruce A. Gustafsen/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3700 Shuger Hill Road, Pikesville, MD 21208</b>	
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Bryan W. Clary</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>	Date <b>9/6/11</b>
		21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
		22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc.</b> <b>10 W. Padonia Rd., Timonium, MD 21093</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
				Approximate Interval Between Onset and Death <b>3 years</b>	
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
				28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. David McGinnis</i>	
		29c. License number <b>D47373</b>		29d. Date signed (Month, Day, Year) <b>9/1/11</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. David McGinnis</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	
		32. Registrar's Signature <i>James J. Parker</i>		33. Original	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28146

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

5  
5  
5State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>Joan M. Sentelle</b>		2. Date of Death Month <b>August</b> Day <b>30</b> , Year <b>2011</b>			3. Time of Death <b>4:20 p M</b>				
4a. Facility Name (if not institution, give street and number) <b>Crofton Convalescent Center, Inc.</b>		4b. City, Town, or Location of Death <b>Crofton</b>			4c. County of Death <b>Anne Arundel</b>				
5. Social Security Number <b>545-36-7862</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 2, 1927</b>	9. Birthplace (State or Foreign Country) <b>VA</b>		
Usual Residence of Decedent		10a. State <b>MD</b>			10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Jessup</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>7503 Gleneagle Dr.</b>		10f. Zip Code <b>20794</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Homemaker</b>		16b. Kind of Business Industry <b>Own Home</b>					
17. Father's Name (First, Middle, Last) <b>George Harry Hottel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beulah Madeline Maphis</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Dennis L. Sentelle/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7503 Gleneagle Drive, Jessup, MD 20794</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>West Arundel Crem.</b>		Date <b>Sept. 2, 2011</b>	20c. Location - City or Town, State <b>Odenton, MD</b>				
21. Signature of Funeral Service Licensee <b>J. Keir Skiles</b>		22. Name and Address of Facility <b>Donaldson Funeral Home, P.A.</b> <b>M01053 313 Talbott Ave., Laurel, MD 20707</b>							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Respiratory pneumonia</i>					Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>D. J. Singh</i>		29c. License number <b>D38958</b>			29d. Date signed (Month, Day, Year) <b>9/1/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Da Jeev Singh Sichu 208 Chain Highway SW Glen Burnie MD 21061</i>									
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <i>Susan J. Parker</i>							

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28147

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Archie Smith</i>					2. Date of Death Month 8 Day 31 Year 11	3. Time of Death 1700 M	
	4a. Facility Name (if not institution, give street and number) <i>University of Maryland Medical Center</i>					4b. City, Town, or Location of Death <i>Baltimore MD</i>	4c. County of Death	
Funeral Director	5. Social Security Number <i>219-94-3892</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Mar. 23, 1969</i>	9. Birthplace (State or Foreign Country) <i>MD</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Carroll</i> 10c. City, Town or Location <i>Hampstead</i>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>644 Boxwood Drive</i>			10f. Zip Code <i>21074</i>	10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>9</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Seconday (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Painter</i>		16b. Kind of Business Industry <i>Painting</i>			
	17. Father's Name (First, Middle, Last) <i>Archie M. Smith, Sr.</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Dorothy Ross</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Casey Drews-Smith Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>644 Boxwood Drive Hampstead, MD 21074</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Carroll Cremation</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Carroll Cremation</i>	Date <i>9/2/11</i>	20c. Location - City or Town, State <i>Hampstead, Maryland</i>			
	21. Signature of Funeral Service Licensee <i>Stephen M Jenkins</i>		22. Name and Address of Facility <i>11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136</i>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Septic Shock</i>					Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of): <i>Septic Shock</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>End Stage Liver Disease</i>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Kelli Eimer MD</i>		29c. License number <i>1417272764</i>			29d. Date signed (Month, Day, Year) <i>8/31/11</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>22 S. Greene St. Baltimore MD 21201</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2011</i> 32. Recorder's Signature <i>Kelli Eimer MD</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

*J. Eimer*State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28148

1 - For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>JANET STRIGLE</b>							2. Date of Death Month <b>September</b> Day <b>2</b> Year <b>2011</b>	3. Time of Death 4:28 PM
4a. Facility Name (if not institution, give street and number) <b>NORTH WEST HOSPITAL</b>							4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>	4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>217-40-4022</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 13, 1941</b>	9. Birthplace (State or Foreign Country) <b>Kentucky</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Marriottsville</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4014 Wards Chapel Road</b>				10f. Zip Code <b>21104</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Manager</b>			16b. Kind of Business Industry <b>Retail Sales</b>		
17. Father's Name (First, Middle, Last) <b>James Adams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hopal Sexton</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Raymond B. Strigle Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4014 Wards Chapel Road Marriottsville, MD 21104</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Evergreen Mem Gardens</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem Gardens</b>			Date <b>9/7/11</b>	20c. Location - City or Town, State <b>Finksburg, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Stephen M. Jenkins</b>		22. Name and Address of Facility <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death <i>Perforated Viscus</i>	
<p>a. Due to (or as a consequence of): <i>Perforated Viscus</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9</b> <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Post-operative ruptured viscus</b>			27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
		28a. Date of injury (Month, Day, Year) <b>09/02/2011</b>	28b. Time of injury <b>unknown</b>	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Post-operative ruptured viscus</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4014 Wards Chapel Road Marriottsville, MD 21104</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>MD</b>		29c. License number <b>D0067210</b>			29d. Date signed (Month, Day, Year) <b>September 2nd 2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Janet K. Strigle</b>							31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Leanne S. Parker</b>

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 78 per FH, G919, 9/13/2011, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28149

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Conrad Lake Schulze, Sr.</b>							2. Date of Death Month 09 Day 02 Year 2011	3. Time of Death 7:00A M	
	4a. Facility Name (if not institution, give street and number) <b>Riverview Rehab. Health Center</b>			4b. City, Town, or Location of Death <b>Essex</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>214-03-3321</b>		6. Sex <input checked="" type="checkbox"/> X M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07/28/1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>10014 Tocabod Lane</b>				10f. Zip Code <b>21220</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Streetcar Driver</b>			16b. Kind of Business Industry <b>Transportation</b>			
	17. Father's Name (First, Middle, Last) <b>Conrad Frederick Schulze</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Lake Smith</b>					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Conrad Schulze, Jr./Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7549 Baltimore Annapolis Blvd Glen Burnie, MD 21060</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Skeir J. Harrell MO1594</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>			Sept Date 8	20c. Location - City or Town, State <b>Glen Burnie, MD</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Skeir J. Harrell MO1594</b>			22. Name and Address of Facility <b>Singleton Funeral &amp; Cremation Services PA 1 2nd Ave SW Glen Burnie, MD 21061</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <b>Atherosclerotic heart disease</b>			23c. Approximate Interval Between Onset and Death <b>10 yrs</b>			
23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23e. Due to (or as a consequence of):							
23f. Due to (or as a consequence of):			23g. Due to (or as a consequence of):							
23h. Due to (or as a consequence of):			23i. Due to (or as a consequence of):							
23j. Due to (or as a consequence of):			23k. Due to (or as a consequence of):							
23l. Due to (or as a consequence of):			23m. Due to (or as a consequence of):							
23n. Due to (or as a consequence of):			23o. Due to (or as a consequence of):							
23p. Due to (or as a consequence of):			23q. Due to (or as a consequence of):							
23r. Due to (or as a consequence of):			23s. Due to (or as a consequence of):							
23t. Due to (or as a consequence of):			23u. Due to (or as a consequence of):							
23v. Due to (or as a consequence of):			23w. Due to (or as a consequence of):							
23x. Due to (or as a consequence of):			23y. Due to (or as a consequence of):							
23z. Due to (or as a consequence of):			23aa. Due to (or as a consequence of):							
23bb. Due to (or as a consequence of):			23cc. Due to (or as a consequence of):							
23dd. Due to (or as a consequence of):			23ee. Due to (or as a consequence of):							
23ff. Due to (or as a consequence of):			23gg. Due to (or as a consequence of):							
23hh. Due to (or as a consequence of):			23ii. Due to (or as a consequence of):							
23jj. Due to (or as a consequence of):			23kk. Due to (or as a consequence of):							
23mm. Due to (or as a consequence of):			23nn. Due to (or as a consequence of):							
23pp. Due to (or as a consequence of):			23qq. Due to (or as a consequence of):							
23rr. Due to (or as a consequence of):			23ss. Due to (or as a consequence of):							
23tt. Due to (or as a consequence of):			23uu. Due to (or as a consequence of):							
23yy. Due to (or as a consequence of):			23zz. Due to (or as a consequence of):							
24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			25. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)			28b. Time of injury M				
28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>Savitha Shivananda</b>			29c. License number <b>D52379</b>			29d. Date signed (Month, Day, Year) <b>9/2/11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Savitha Shivananda 1124 Mace Avenue Baltimore Md 21221</b>			31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>			32. Registrar's Signature <b>Savitha J. Parker</b>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transitpermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

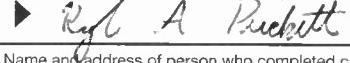
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar Amend Item 25 per me, g, 918, 08/25/2011 and

State of Maryland Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 28150

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM FREDERICK SIMPKINS</b>							2. Date of Death Month <b>JULY</b> Day <b>12</b> Year <b>2011</b>	3. Time of Death <b>7:19 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death			
Funeral Director	5. Social Security Number <b>216-44-5286</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>12/11/1946</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>390 Cork Road</b>				10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates,		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>			16b. Kind of Business Industry <b>Construction</b>			
	17. Father's Name (First, Middle, Last) <b>George Simpkins, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia E. Tudor</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Viola Stafford / Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>390 Cork Road, Glen Burnie, MD 21060</b>			20c. Location - City or Town, State <b>Woodbine, MD</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crem.</b>			Date <b>7/15/2011</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Maryland Cremation Services PO Box 1413, Baltimore, MD 21203</b>						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>SEPTIC SHOCK</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 WEEKS</b>	
	b. <b>CELLULITIS</b> Due to (or as a consequence of):									
	c. <b>ACUTE KIDNEY INJURY</b> Due to (or as a consequence of):									
	d. <b>HYPER TENSION, CONGESTIVE HEART FAILURE, STROKE, SEIZURE DISORDERS, PERIPHERAL VASCULAR DISEASE</b>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, CONGESTIVE HEART FAILURE, STROKE, SEIZURE DISORDERS, PERIPHERAL VASCULAR DISEASE</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 			29c. License number <b>RES 001</b>			29d. Date signed (Month, Day, Year) <b>JULY, 12, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kyle Prickett</b>			31. Date filed (Month, Day, Year) <b>AUG 25 2011</b>			32. Registrar's Signature 			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

say to me

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28151

1- For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>STANLEY J. SCHAPIRO</b>						2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2011</b>		3. Time of Death <b>5:45 PM</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>COURTLAND GARDENS</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>BALTIMORE</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>220-14-6127</b>	6. Sex <b>1 M</b>	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>02/03/1924</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>BALTIMORE</b>			10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <b>1 Yes</b> <b>2 No</b>			
		10e. Street and Number <b>1 POMONA EAST, APT. 208</b>			10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status <b>1 Never Married</b> <b>2 Married</b> <b>3 Widowed</b> <b>4 Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes</b> <b>2 No</b> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes</b> <b>2 No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>5 +</b>	16b. Kind of Business Industry <b>ATTORNEY</b>							
		17. Father's Name (First, Middle, Last) <b>WILLIAM SCHAPIRO</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>FREDA ROSEN</b>								
		19a. Informant's Name/Relationship (Type, Print) <b>SHIRLEY SCHAPIRO/WIFE</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 POMONA EAST, APT. 208</b>	19c. Date <b>09/02/2011</b>			20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>				
		20a. Method of Disposition <b>1 Burial</b> <b>2 Cremation</b> <b>3 Removal from State</b> <b>4 Donation</b> <b>5 Other (Specify)</b>	20b. Place of Disposition (Name of Cemetery, Crematory or other place) <b>MEMORIAL PARK</b>								
		21. Signature of Funeral Service Licensee <b>S. Schapiro</b>	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>								
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) <b>Bladder cancer</b>						Approximate Interval Between Onset and Death			
		a. Due to (or as a consequence of): <b>Bladder cancer</b>									
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes</b> <b>2 No</b> <b>9 Unknown</b>	23c. If yes, outcome of pregnancy <b>1 Live Birth</b> <b>2 Fetal death</b> <b>3 Ectopic pregnancy</b> <b>4 Pregnant at time of death</b> <b>5 Other (specify)</b> <b>9 Unknown</b>	23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 Yes</b> <b>2 No</b> <b>3 Probably</b> <b>4 Unknown</b>			
								24a. Was an autopsy performed? <b>1 Yes</b> <b>2 No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes</b> <b>2 No</b>		
		25. Was case referred to medical examiner? <b>1 Yes</b> <b>2 No</b>	Hospital: <b>1 Inpatient</b> <b>2 ER/Outpatient</b> <b>3 DDA</b>	Other: <b>4 Nursing Home</b> <b>5 Residence</b> <b>6 Other (Specify)</b>	26. Place of Death (Check only one)						
		27. Manner of Death <b>1 Natural</b> <b>2 Accident</b> <b>3 Suicide</b> <b>4 Homicide</b>	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 Yes</b> <b>2 No</b>	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		29a. Certifier (Check only one) <b>1 Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>3 Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier <b>Dana Jason CNP</b>	29c. License number <b>N113410</b>	29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dana Jason CNP 7920 Sutliff Rd Baltimore MD 21208</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Shane L. Patel</b>								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 ✓

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28152

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Smith

2. Date of Death

Month Day Year  
08 28 2011

3. Time of Death

0814 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5. Social Security Number

216-18-0586

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month Day Year  
03 27 1925

3. Time of Death

0814 M

Usual Residence of Decedent

10a. State  
MD10b. County  
Anne Arundel10c. City, Town or Location  
Annapolis10d. Inside City Limits  
1  Yes 2  No

10e. Street and Number

84 Old Mill Bottom Road

10f. Zip Code

21409

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Seconday (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Homemaker

17. Father's Name (First, Middle, Last)

Occhionero

18. Mother's Name (First, Middle, Maiden Surname)

Augusta

19a. Informant's Name/Relationship (Type, Print)

Nancy J. Smith Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 East Lake Drive Annapolis MD 21403

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crem

Date

8/30/11

20c. Location - City or Town, State

Glen Burnie MD

21. Signature of Funeral Service Licensee

Thomas Allen PA

22. Name and Address of Facility

Simplicity Crem &amp; Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

{

- a. Due to (or as a consequence of):  
*myocardial infarction*
- b. Due to (or as a consequence of):  
*hypertension*
- c. Due to (or as a consequence of):  
*diabetes mellitus*
- d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*amyotrophic lateral sclerosis*

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DDA

26. Place of Death (Check only one)

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D Moser

29c. License number

D16376

29d. Date signed (Month, Day, Year)

8/31/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph D Moser 2001 Medical Hwy, Annapolis MD 21401

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Kris J. Spahr

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28153

**Physician/  
Medical Examiner****1-For State  
Registrar**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1449 hrs
<b>Barbara Jeanne Shaffer</b>		

4a. Facility Name (if not institution, give street and number) <b>3304 Floral Street</b>	4b. City, Town, or Location of Death <b>Silver Spring</b>	4c. County of Death <b>Montgomery</b>
---	--	--

**Funeral  
Director**

5. Social Security Number <b>220-88-6554</b>	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>09/17/1961</b>	9. Birthplace (State or Foreign Country) <b>WashDC</b>
		<b>Yrs.</b>			

10a. State <b>PA</b>	10b. County <b>Bedford</b>	10c. City, Town or Location <b>Breezewood</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number <b>177 Mobile Court Road</b>	10f. Zip Code <b>15533</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc.
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6yrs</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>	16b. Kind of Business/Industry <b>Restaurant</b>
--	--	---

17. Father's Name (First, Middle, Last) <b>Donald Hite</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Beverly Moore</b>
---	---

19a. Informant's Name/Relationship (Type, Print) <b>David G. Shaffer Sr Husband</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>177 Mobile Court Rd Breezewood PA 15533</b>
--	---

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crem</b>	Date <b>8/31/11</b>	20c. Location - City or Town, State <b>Glen Burnie MD</b>
<input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensee <b>Thomas Allen PA</b>	22. Name and Address of Facility <b>Simplicity Crem &amp; Fun Serv ThomasAllenPA 7090 Ridge RD Hanover MD</b>
---	--

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician /Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. <b>Phencyclidine (PCP) and Methadone Intoxication</b> Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
	c. Due to (or as a consequence of):
	d. Due to (or as a consequence of):

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g919 9-8-11 sm
IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown
23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year

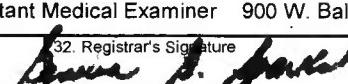
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	26. Place of Death (Check only one)
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>fd 8-4-11</b>	28b. Time of Injury <b>fd 2:40 pm</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Unknown</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence of friend</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3304 Floral St. Silver Spring, Md.</b>	

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 5, 2011</b>
---	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature 	OCME
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 2 per doc g919 9-6-11 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28154

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
*Terry Hoyt Thomas*

2. Date of Death 28  
Month Day Year  
*Aug 11 2011*

3. Time of Death  
*1415 M*

4a. Facility Name (If not institution, give street and number)  
*761 218th Street*

4b. City, Town, or Location of Death  
*PASADENA*

4c. County of Death  
*AA*

Funeral  
Director

5. Social Security Number  
*217-64-4417*

6. Sex  
 M  F

7. Age (In yrs. last birthday)  
*59*

8. If Under 1 Year  
Months Days Hours Min.

9. Date of Birth  
(Month, Day, Year)  
*2/6/1952*

10. Birthplace (State or Foreign Country)  
*SC*

To Be Completed by Funeral Director

Usual Residence of Decedent  
10a. State  
*MD*

10b. County  
*ANNE ARUNDEL*

10c. City, Town or Location  
*PASADENA*

10d. Inside City Limits  
 Yes  No

10e. Street and Number  
*761 218TH ST*

10f. Zip Code  
*21122*

10g. Citizen of What Country?  
*USA*

11. Marital Status  
 Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
 Yes  No  
If Yes, Give Year or Dates:  
*Year or Dates:*

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No  
Specify:  
*WHITE*

14. Race - American Indian, Black, White, etc.  
Specify:  
*WHITE*

15. Decedent's Education  
(Specify only highest grade completed)  
*Elementary/Secondary (0-12) 12*

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)  
*PRINTING*

16b. Kind of Business/Industry  
*ANNE ARUNDEL COMMUNITY COLLEGE*

17. Father's Name (First, Middle, Last)  
*HENRY THOMAS*

18. Mother's Name (First, Middle, Maiden Surname)  
*LEORA ADAMS*

19a. Informant's Name/Relationship (Type, Print)  
*TERRY THOMAS-SON*

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
*991 CHERRY RUN RD BEDFORD, PA 15522*

20a. Method of Disposition  
 Burial  Cremation  Removal from State  
 Donation  Other (Specify)  
*Burial*

20b. Place of Disposition (Name of cemetery, crematory or other place)  
*HARFORD MEM. GARDENS*

Date

20c. Location - City or Town, State

*8/31/11 BEL AIR, MD*

21. Signature of Funeral Service Licensee  
*Bruce A. Miller*

22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR  
*610 W. MACPHAIL RD BEL AIR, MD 21014*

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. *Arteriosclerotic Heart Disease*  
Due to (or as a consequence of):

b. \_\_\_\_\_  
Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
 Yes  No  Unknown

23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
 Yes  No  Probably  Unknown

25. Was case referred to medical examiner?  
 Yes  No

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death  
 Natural  Pending investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
28c. Injury at Work?  
M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
*William P. Jones, MD*

29c. License number  
*D 06054*

29d. Date signed (Month, Day, Year)  
*8/30/11*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
*William P. Jones, MD 4095 America 21035*

31. Date filed (Month, Day, Year)  
*SEP 06 2011*

32. Registrar's Signature  
*Laura J. Parker*

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28155

1- For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Raymond Frank Tudino</b>				2. Date of Death Month <b>August</b> Day <b>25</b> Year <b>2011</b>		3. Time of Death <b>10:18 PM</b>		
	4a. Facility Name (if not institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>None</b>		
<b>Funeral Director</b>	5. Social Security Number <b>088-54-8778</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>December 14, 1964</b>	9. Birthplace (State or Foreign Country) <b>Rhode Island</b>		
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b>				10c. City, Town or Location <b>Fort George G. Meade</b>				
	10e. Street and Number <b>8792 Foster Circle</b>				10f. Zip Code <b>20755</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give <b>08/15/1984</b> Year or Dates - <b>Present</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> 3 <b>Senior Non-Commissioned Officer</b>		16b. Kind of Business Industry <b>United States Air Force</b>				
	17. Father's Name (First, Middle, Last) <b>Erasmo Tudino</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anita Carbocci</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Shelley L. Tudino/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8792 Foster Circle, Fort George G. Meade, MD 20755</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Will E. Brown Jr M00672</b>		20b. Place of Disposition (Name of Cemetery/Crematory/other place) <b>West Arundel Crematory</b>		Date <b>September 3, 2011</b>	20c. Location - City or Town, State <b>Odenton, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>► Will E. Brown Jr M00672</b>				22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113</b>				
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>End-stage cardiomyopathy</b></p> <p>b. Due to (or as a consequence of): <b>Acute aortic regurgitation</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>g Unknown</b>			23d. Date of delivery Month Day Year			
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>RES - 000</b>			29d. Date signed (Month, Day, Year) <b>August 26, 2011</b>			
	29b. Signature and title of certifier <b>► Harsh Patel MD</b>		29c. License number <b>RES - 000</b>			29d. Date signed (Month, Day, Year) <b>August 26, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harsh Patel MD, 600 North Wolfe Street, Baltimore, Maryland 21287</b>		31. Date filed (Month Year) <b>SEP 06 2011</b>			32. Registrar's Signature <b>Anna J. Patel</b>			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28156  
Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

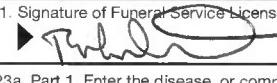
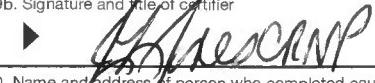
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 6:45 PM	
Joseph Walter Thompson, Sr.		August 28, 2011			
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Stella Maris Hospice		Timonium		Baltimore	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 5, 1948	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State Md. 10b. County Baltimore 10c. City, Town or Location Eastwood			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 7244 Gough Street		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Warehouseman		16b. Kind of Business Industry Warehouseman	
17. Father's Name (First, Middle, Last) Joseph Elmer Thompson			18. Mother's Name (First, Middle, Maiden Surname) Madeline Wachter		
19a. Informant's Name/Relationship (Type, Print) Patricia Thompson/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7244 Gough Street Baltimore, Md. 21224			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		20c. Location - City or Town, State September 1, 2011 Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md. 21222			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. <b>LUNG CANCER</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number R149792		29d. Date signed (Month, Day, Year) 8/29/2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>					
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature 			

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28157

Physician/  
Medical  
Examiner1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

		1. Decedent's Name (First, Middle, Last) <b>LARRY THOMAS</b>			2. Date of Death Month <b>08</b> Day <b>30</b> Year <b>2011</b>	3. Time of Death <b>11:14 A.M.</b>			
		4a. Facility Name (if not institution, give street and number) <b>BALTIMORE WASHINGTON MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>GLEN BURNIE</b>	4c. County of Death <b>ANNE ARUNDEL</b>			
Funeral Director		5. Social Security Number <b>219-26-1805</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>73 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>03-22-1938</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Severn</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>1424 Maryland Avenue</b>			10f. Zip Code <b>21144</b>			10g. Citizen of What Country? <b>United States</b>	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operations Specialist</b>			16b. Kind of Business Industry <b>U.S. Navy</b>		
		17. Father's Name (First, Middle, Last) <b>Robert Edward Thomas</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Helen White</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Thomas / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1424 Maryland Avenue Severn, Maryland 21144</b>				
Physician/ Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>MD Veterans Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>09-07-2011</b>	20c. Location - City or Town, State <b>Crownsville, Maryland</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Person 		22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113</b>					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASPIRATION PNEUMONITIS</b>				Approximate Interval Between Onset and Death			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{ SMALL BOWEL OBSTRUCTION</b>							
		23b. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>ATRIAL FIBRILLATION</b> <b>HYPERTENSION</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier 		29c. License number <b>D69090</b>		29d. Date signed (Month, Day, Year) <b>08/30/2011</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tarau Reddy, MD 301 Hospital Drive Glen Burnie, Maryland 21061</b>							
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

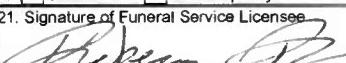
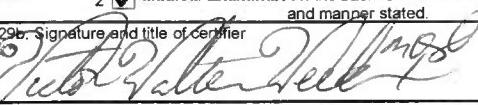
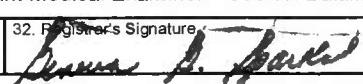
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28158

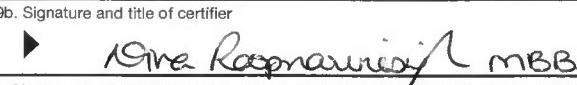
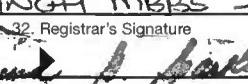
Reg. No.

**1- For State Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Prem Venkatasubramanian</b>					2. Date of Death Month Day Year <b>August 28, 2011</b>	3. Time of Death <b>1117 hrs</b>		
						4a. Facility Name (if not institution, give street and number) <b>702 Elm Road RM 2412</b>		4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death <b>Anne Arundel</b>
<b>Funeral Director</b>	5. Social Security Number <b>277-17-2950</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>22</b>	Yrs. If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>Dec. 2, 1988</b>	9. Birthplace (State or Foreign Country) <b>India</b>	
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Ohio</b> 10b. County <b>Franklin</b> 10c. City, Town or Location <b>Columbus</b>								10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1444 Worthington Street Apt F</b>				10f. Zip Code <b>43201</b>		10g. Citizen of What Country? <b>India</b>		
	11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Indian</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Student</b>				
	17. Father's Name (First, Middle, Last) <b>Venkatasubramaniam T V</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alamelu R</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Naveen Parthasarathy-Cousin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8359 Chwdw Lane W Drive Apt 3B Indianapolis In 46208</b>						
<b>Physician Medical Examiner</b>	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>		Date <b>Aug 30 2011</b>	20c. Location - City or Town, State <b>Glen Burnie Maryland</b>			
	4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:								
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ambrose Funeral Home Inc.</b>		1328 Sulphur Spring Road Arbutus Maryland 21227				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. <b>Asphyxiation from Vitiated Atmosphere</b> Due to (or as a consequence of):								
	b. _____ Due to (or as a consequence of):								
	c. _____ Due to (or as a consequence of):								
	d. _____								
	<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene						
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)		28a. Date of Injury (Month, Day, Year) <b>FOUND: Aug 28, 2011</b>	28b. Time of Injury <b>FOUND: 1100 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject put bag over his head with connection to helium source			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>motel</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>7032 Elm Road RM 2412, Baltimore, MD</b>				
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
					29c. License number <b>O.C.M.E.</b>				
					29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) <b>Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>								
	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Items 23a&t1,25,27,28a-f per me, g918, 08/31/2011 dnb  
Certificate of Death  
Reg. No. 2011 28159

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLARENCE WHYE</b>				2. Date of Death Month Day Year <b>August 13 2011</b>	3. Time of Death <b>22:32 M</b>	
	4a. Facility Name (if not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>218-26-0363</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days Hours Min. <b>04/05/1929</b>	8. Date of Birth (Month, Day, Year) <b>04/05/1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County 10c. City, Town or Location <b>Baltimore</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>4017 Liberty Heights Avenue</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondday (0-12) Unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Horse Groomer</b>		16b. Kind of Business Industry <b>Horse Racing</b>		
	17. Father's Name (First, Middle, Last) <b>Unknown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Annabell Wilson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Stephanie Carey / Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 W. Garrison Ave., Baltimore, Maryland 21215</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		Date <b>08/19/2011</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>The Derrick C. Jones F/H, P.A.</b>		<b>4611 Park Hgts. Ave., Baltimore, Maryland</b>		
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Aspiration pneumonia</b> Approximate Interval Between Onset and Death <b>5 days</b>						
	a. Due to (or as a consequence of): <b>Cerebrovascular Accident</b> Approximate Interval Between Onset and Death <b>3 hrs</b>						
	b. Due to (or as a consequence of): <b>Non ST elevation myocardial Infarction</b> Approximate Interval Between Onset and Death <b>1 min</b>						
	c. Due to (or as a consequence of): <b>G I bleed</b> Approximate Interval Between Onset and Death <b>1 hr</b>						
	d. Due to (or as a consequence of): <b>Subdural hematoma</b> Approximate Interval Between Onset and Death <b>1 hr</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						
	23d. Date of delivery Month Day Year						
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>G I bleed</b>						
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) <b>Found: 06/30/2007</b> 28b. Time of injury <b>Unknown M</b> 28c. Injury at work? <b>Unknown</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	28d. Describe how injury occurred <b>Unknown</b>						
	28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Found: 5201 Park Heights Avenue, Baltimore, MD</b>						
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier  29c. License number <b>PES-000</b> 29d. Date signed (Month, Day, Year) <b>August 13 2011</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NIRAJ ROOPNARINEEGBH MBBS 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD</b>						
	31. Date filed (Month, Day, Year) <b>AUG 17 2011</b> 32. Registrar's Signature 						

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**State of Maryland / Department of Health and Mental Hygiene  
Amend Item 8 per th, g, 09/07/2011dmb/dvr

2011 28160

1-For State  
Registrar

Certificate of Death

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Harry M. Williams</b>						2. Date of Death Month Day Year August 31, 2011	3. Time of Death 1503 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Johns Hopkins Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death		
To Be Completed by Funeral Director		5. Social Security Number <b>053-32-8766</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>06/12/1940</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Gwynn Oak</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number <b>5934 Johnnycake Road</b>			10f. Zip Code <b>21207</b>			10g. Citizen of What Country? <b>USA</b>		
Physician /Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Agent</b>			16b. Kind of Business/Industry <b>John Hopkins Hosp</b>		
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Carroll Williams</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Etta Davis</b>					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Carl Davis (Uncle)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5934 Johnnycake Rd., Gwynn Oak, MD 21207</b>					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>Vaughn C. Phesse</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>	Date <b>9-13-11</b>	20c. Location - City or Town, State <b>Owings Mills, MD</b>					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Vaughn C. Phesse</b>	22. Name and Address of Facility <b>Vaughn C. Greene Funeral Services 515 Battle. Nat'l Pike (21229)</b>							
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner		<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED								
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:						
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner										
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 1, 2011</b>			
State Registrar		30. Name and address of person who completed cause of death (Item 23a) <b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>								
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G922,12/7/2011,WS

State of Maryland / Department of Health and Mental Hygiene

2011 28161

## Certificate of Death

Reg. No.

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

		1. Decedent's Name (First, Middle, Last)			Ward			2. Date of Death	Month	Day	Year	3. Time of Death			
		Michael						September 1 2011			0107 M				
		4a. Facility Name (if not institution, give street and number)			The Johns Hopkins Hospital			4b. City, Town, or Location of Death			Baltimore CITY				
		5. Social Security Number			6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)				
		214-62-9664			1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	57 Yrs.		Months	Days	Month Day Year	NOV 6, 1954				
		Usual Residence of Decedent			10a. State			10c. City, Town or Location			10d. Inside City Limits				
					MD			Baltimore			<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			USA				
		1111 N. Kenwood Ave			21213										
		11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Specify: Black				
		3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			If Yes, Give Year or Dates.										
		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry							
		Elementary/Secondary (0-12) 12			College (1-4 or 5+) Crain Operator			Beth Steel							
		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)										
		Leonard Ward			Elizabeth Allen										
		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
		Brenda Ward			1111 N. Kenwood Ave, Balto. MD 21213										
		20a. Method of Disposition			20b. Place of Disposition (Name of Cemetery, crematory or other place)			Date	20c. Location - City or Town, State						
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			Arbutus			9/9/2011	Baltimore, MD						
		4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)													
		21. Signature of Funeral Service Licensee			22. Name and Address of Facility										
		Brenda Ward			Howell Funeral Home										
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			23b. Immediate Cause (Final disease or condition resulting in death)			23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			23d. Approximate Interval Between Onset and Death				
					{			a. Due to (or as a consequence of): Sepsis							
					{			b. Due to (or as a consequence of):							
					{			c. Due to (or as a consequence of):							
					{			d. Due to (or as a consequence of):							
		IF FEMALE:			23c. If yes, outcome of pregnancy			23d. Date of delivery							
		23b. Was decedent pregnant in the past 12 months?			1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			Month Day Year							
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
		25. Was case referred to medical examiner?			26. Place of Death (Check only one)			23e. Did tobacco use contribute to the cause of death?							
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
		27. Manner of Death			28a. Date of injury (Month, Day, Year)			28b. Time of injury	M	28c. Injury at work?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined													
		3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier			1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number			29d. Date signed (Month, Day, Year)				
		29b. Signature and title of certifier			RES-000			September 1, 2011							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Matthew J. DeAngelis			600 N Wolfe St. Baltimore MD 21207							
		31. Date filed (Month, Day, Year)			SEP 06 2011			32. Registrar's Signature			Anna S. Farad				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28162

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death		
		<i>Myra Wright</i>			Month <i>August</i> Day <i>26</i> Year <i>2011</i>		Reg. No. <i>1245P M</i>		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death		
		<i>Seasons Hospice Northwest</i>			<i>Randallstown</i>		<i>Baltimore</i>		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
		<i>213-78-2347</i>	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	53 Yrs.	Months	Days	Month <i>Jan</i> Day <i>27</i> Year <i>1958</i>		
		Usual Residence of Decedent			Hours Min.		9. Birthplace (State or Foreign Country)		
		10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		<i>MD</i>	<i>N/A</i>	<i>Baltimore</i>					
		10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?		
		<i>2314 Cloville Ave</i>			<i>21214</i>		<i>USA</i>		
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				
		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
		<i>Elementary/Secondary (0-12)</i>			<i>Clerical Administrator</i>		<i>FBI</i>		
		College (1-4 or 5+)							
		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)				
		<i>William A. Wright Sr</i>			<i>Annie Mae Adams</i>				
		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
		<i>Ben F. Wright</i>			<i>2314 Cloville Ave, Baltimore, MD 21214</i>				
		20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			<i>King Memorial Park</i>		Date <i>9/21/2011</i> Baltimore, MD		
		21. Signature of Funeral Service License			22. Name and Address of Facility				
		<i>Bruand Funeral Services</i>			<i>Howell Funeral Home</i>				
					<i>41600 Liberty Heights Ave, Balt. MD 21207</i>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition resulting in death)							
		a. <i>Myelodysplastic syndrome</i> Due to (or as a consequence of):							
		b. <i>Acute myeloid leukemia</i> Due to (or as a consequence of):							
		c. _____ Due to (or as a consequence of):							
		d. _____ Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Inpatient Hospice</i>					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier <i>Dorothy Seay MD</i>		29c. License number <i>DOOS3337</i>			29d. Date signed (Month, Day, Year) <i>August 27 2011</i>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<i>Dorothy Seay MD 2835 Smith Avenue Ste 203 Baltimore, Md 21209</i>					
		31. Date filed (Month, Day, Year)		32. Registrar's Signature <i>Anna J. Pace</i>					

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 26 per doc g919 9-6-11 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28164

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy M. Wilson</b>				2. Date of Death Month Day Year <b>08-31-2011</b>	3. Time of Death <b>10:05 AM</b>			
	4a. Facility Name (if not institution, give street and number) <b>5306 READY AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death				
Funeral Director	5. Social Security Number <b>212-26-1756</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>04-25-1927</b>	9. Birthplace (State or Foreign Country) <b>SC</b>			
	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number <b>5306 READY AVE</b>			10f. Zip Code <b>21212</b>	10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>8</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CAFETERIA WORKER</b>		16b. Kind of Business Industry <b>LUMBAR Middle School</b>				
	17. Father's Name (First, Middle, Last) <b>WILLIE HARLEY</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY FRANK</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA RODMAN (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5105 OLD COURT ROAD. RANDALLSTOWN, MD. 21133</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>RHOMES</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crownsville VA Cemetery</b>		Date <b>9/8/11</b>	20c. Location - City or Town, State <b>CROWNSVILLE, MD</b>			
	21. Signature of Funeral Service Licensee <b>RHOMES</b>		22. Name and Address of Facility <b>VAUGHN GREENE FUNERAL SVCS 4905 YORK ROAD. BALTIMORE, MD. 21212</b>						
Physician Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Infected Foot -</b>						Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of): <b>peripheral Vasculon Disease</b></p> <p>b. Due to (or as a consequence of): <b>CAO</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension / Dialysis.</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier <b>MD</b>		29c. License number <b>041536</b>		29d. Date signed (Month/Day/Year) <b>09/01/2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anissa MEE 2A 18601 Cork Raven Blvd, Balt. MD 21230</b>								
State Registrar	31. Date filed (Month/Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>James P. Parker</b>						

10:05 AM  
8-31-11

Dorothy M. Wilson  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No.

2011 28165

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Mary Weems</b>				2. Date of Death Month Day Year <b>August 29 2011 0040 AM</b>		3. Time of Death <b>0040 AM</b>			
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>319-44-8144</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>7-4-1944</b>			
		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>			
		10e. Street and Number <b>3811 Elmcroft Road</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business Industry <b>Domestic</b>					
		17. Father's Name (First, Middle, Last) <b>Clifford Weems</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah C. Batty</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Robin Clark/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2102 Park Place, Gwynn Oak, MD 21207</b>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Cremation</b>		20b. Place of Disposition (Name of Cemetery, crematory or other place) <b>Green Mount</b>		Date <b>9-9-2011</b>	20c. Location - City or Town, State <b>Baltimore MD</b>				
		21. Signature of Funeral Service Licensee <b>Vanessa C. Kuehn</b>		22. Name and Address of Facility <b>Vanessa C. Greene Funeral Services 8728 Liberty Road, Randallstown, MD 21133</b>							
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive heart failure</b>								Approximate Interval Between Onset and Death	
		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>renal failure</b>									
		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
		27. Manner of death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <b>Dr. Laura Harlan</b>	
		29c. License number <b>H0051339</b>								29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Laura Harlan 5101 Old Ct. Rd. Randallstown MD 21133</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>				32. Registrar's Signature <b>Laura J. Harlan</b>					

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## **Medical Certificate: To Be Completed by Physician/Medical Examiner**

To Be Completed by Funeral Director

## **1 - State Registrars**

## **Physician/ Medical Examiner**

**Funeral  
Director**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28166

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Steven A. Wright

2. Date of Death

Month Day Year  
08 27 2011

3. Time of Death

5:18 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

212-46-1547

6. Sex

1 M

2 F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02/11/1947

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

11205 Sheradale Drive

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 □ Never Married 2 X Married  
3 □ Widowed 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+) 4

16b. Kind of Business Industry

Automotive

Retail Sales

17. Father's Name (First, Middle, Last)

Albert Bender Wright

18. Mother's Name (First, Middle, Maiden Surname)

Doris Evelyn Shoemake

19a. Informant's Name/Relationship (Type, Print)

Kay Wright (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11205 Sherdale Drive - Kingsville, Maryland 21087

20a. Method of Disposition

1 □ Burial 2 X Cremation 3 □ Removal from State  
4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Metro Crematory, Inc. 08/29/2011 Baltimore, Maryland

21. Signature of Funeral Service Licensee

► E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home, P.A.

11750 Belair Road - Kingsville, Maryland 21087

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrest

Approximate Interval Between Onset and Death

Equally likely conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Severe Intraventricular Hemorrhage

Due to (or as a consequence of):

History of Brain Aneurysm Surgery and

Due to (or as a consequence of):

Hypertension

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 □ Yes 2 □ No 9 □ Unknown

23c. If yes, outcome of pregnancy

1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy  
4 □ Pregnant at time of death 5 □ Other (specify)  
9 □ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 □ Yes 2 X No 3 □ Probably 4 □ Unknown

25. Was case referred to medical examiner?  
1 □ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)

27. Manner of Death

1 X Natural 5 □ Pending Investigation  
2 □ Accident 6 □ Could not be determined  
3 □ Suicide  
4 □ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 □ Yes 2 □ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4 □ Other (Specify)

29b. Signature and title of certifier

► Asima Rahman

29c. License number

RES0000

29d. Date signed (Month, Day, Year)

8-27-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asima Rahman, MD 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

SEP 01 2011

32. Registrar's Signature

Asima S. Rahman

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend Item 1 per doc g919 9-14-11 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28167

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		<b>Franciszek P. Wielgus</b>				2. Date of Death	Month	Day	Year	3. Time of Death					
<b>FRANCISZEK P. WIELGUS</b>						09	04	2011	0310 PM						
4a. Facility Name (if not institution, give street and number)		Seasons Hospice at Northwest Hospital				4b. City, Town, or Location of Death		Randallstown							
4c. County of Death		Baltimore													
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)							
216-06-4948		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	84 Yrs.	Months	Days	Hours	Min.	12/07/1926		Poland					
Usual Residence of Decedent		10a. State Md				10b. County Carroll				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>2721 Old Liberty Rd</b>				10f. Zip Code <b>21784</b>				10g. Citizen of What Country? <b>USA</b>							
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8Yrs</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>				16b. Kind of Business/Industry <b>Carpentry</b>							
17. Father's Name (First, Middle, Last) <b>Jan Wielgus</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Lizak</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Victoria Jane Green (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2721 Old Liberty Rd. Eldersburg, Md. 21784.</b>											
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State							
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>All County Cremation</b>		All County Cremation			09/06/2011			Sykesville, Md.							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md. 21784.</b>											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)															
a. <b>End-stage liver disease</b> Due to (or as a consequence of):															
b. _____ Due to (or as a consequence of):															
c. _____ Due to (or as a consequence of):															
d. _____															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospice Inpatient unit</b>													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At Lee Hospital, MD 2835 Smith Ave. #203, Baltimore, MD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D67220</b>													
29b. Signature and title of certifier  <b>MD.</b>		29d. Date signed (Month, Day, Year) <b>09/04/2011</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lee Hospital, MD 2835 Smith Ave. #203, Baltimore, MD</b>															
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 													

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 26, 30perPHYS, G919, 9/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene

2011 28168

1. For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kyle Whelan</b>							2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2011</b>	3. Time of Death <b>5:07 AM</b>
	4a. Facility Name (if not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>046-82-8930</b>	6. Sex <b>XX M</b>	7. Age (In yrs. last birthday) <b>26 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 28, 1985</b>	9. Birthplace (State or Foreign Country) <b>Connecticut</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>XX Yes</b> <b>2 No</b>	
	10e. Street and Number <b>3148 Remington Avenue</b>			10f. Zip Code <b>21211</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1XX Never Married</b> <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2 XX</b> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2 XX</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bartender</b>			16b. Kind of Business Industry <b>Restaurant</b>		
	17. Father's Name (First, Middle, Last) <b>L. Robert Whelan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Patricia Woodhouse</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Lyman Robert Whelan</b> Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 462 Sharon, CT 06069</b>					
	20a. Method of Disposition <b>1</b> Burial <b>2 X</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>			Date <b>9/2/2011</b>		
Physician/ Medical Examiner	21. Signature of Funeral Service License <b>Dawn B. Huss</b>			22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>			20c. Location - City or Town, State <b>Glen Burnie, Maryland Atlantic Crematory</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death				
	<p>a. Due to (or as a consequence of): <b>Ventricular Tachycardia</b></p> <p>b. Due to (or as a consequence of): <b>Cardiomyopathy</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>				<b>5 years</b>				
	23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2</b> No <b>9</b> Unknown			23c. If yes, outcome of pregnancy <b>1</b> Live Birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy <b>4</b> Pregnant at time of death <b>5</b> Other (specify) <b>9</b> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2 XX</b> No <b>3</b> Probably <b>4</b> Unknown								
	24a. Was an autopsy performed? <b>1</b> Yes <b>2 XX</b> No			24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2 XX</b> No			26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3 XX</b> DOA Other: <b>4</b> Nursing Home <b>5 XX</b> Residence <b>6</b> Other (Specify)					
	27. Manner of Death <b>1 XX</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1</b> Yes <b>2</b> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <b>1 XX</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>3</b> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <b>D-54594</b>			29d. Date signed (Month, Day, Year) <b>September 1, 2011</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bruce Watson Union Memorial Hospital Baltimore, MD 21218</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Bruce Watson</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28169

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Weissner

2. Date of Death

Month 9 Day 85 Year 2011

3. Time of Death

4:58 PM

4a. Facility Name (if not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

N/A

5. Social Security Number

220724558

6. Sex

M  F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

Month, Day, Year

APR. 26, 1959

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes  No

10e. Street and Number

5215 EASTERN AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No.)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 6 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business Industry

N/A

17. Father's Name (First, Middle, Last)

RUSSELL HERBERT WEISSNER

18. Mother's Name (First, Middle, Maiden Surname)

JEAN REBECCA NEWHOUSE

19a. Informant's Name/Relationship (Type, Print)

LORETTA BAKER/ SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 ORSBURN DRIVE, JOPPA, MARYLAND 21085

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BAYVIEW CREMATORY

Date

9/6/11

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME 21224  
700 S. CONKLING STREET, BALTIMORE, MD

Approximate Interval Between  
Conse and Death  
8 days

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Fungal Peritonitis

b. Due to (or as a consequence of):

Septic Shock

c. Due to (or as a consequence of):

Cirrhosis

d. Due to (or as a consequence of):

Alcoholism

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

26. Place of Death (Check only one)

Inpatient

ER/Outpatient

DOA

Other:

4  Nursing Home

5  Residence

6  Other (Specify)

27. Manner of Death

Natural  
2  Accident  
3  Suicide  
4  Homicide

5  Pending Investigation  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0067708

29d. Date signed (Month, Day, Year)

9/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Andrews 301 St Paul Place Baltimore MD

31. Date filed (Month, Day, Year)

SEP 06 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28170

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leona Weil</b>					2. Date of Death Month <b>August</b> Day <b>26</b> , Year <b>2011</b>	3. Time of Death 6:10 PM	
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist</b>			4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>		
Funeral Director	5. Social Security Number <b>328-18-5897</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months      Days	If Under 24 Hrs. Hours      Min.	8. Date of Birth (Month, Day, Year) <b>Dec 27, 1920</b>	9. Birthplace (State or Foreign Country) <b>Illinois</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Howard</b>			10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>3214 Bicentennial Court</b>			10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>			16b. Kind of Business Industry <b>Accounting</b>	
	17. Father's Name (First, Middle, Last) <b>Harry Moscovitz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Kafka</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lauren L. Bernadzikowski/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3214 Bicentennial Ct. Ellicott City, MD 21042</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey Crematory</b>		Date <b>09/01/11</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>		
	21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b>		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. <b>Performed diverticulitis abscess</b> Due to (or as a consequence of): <b>June 2011</b>							
	b. _____ Due to (or as a consequence of):							
	c. _____ Due to (or as a consequence of):							
	d. _____							
	Approximate Interval Between Onset and Death							
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>Unknown</b>				23d. Date of delivery Month      Day      Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteric stenosis, atrial fibrillation, presacral space abscess</b>							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Rebecca Sutula CNP</b>				29c. License number <b>R145356</b>		29d. Date signed (Month, Day, Year) <b>August 27, 2011</b>	
	29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rebecca Sutula 16336 cedar lane Columbia MD 210415</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <b>Rebecca Sutula</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28171

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August Day 31, 2011 Year		3. Time of Death 5:20 P M
Shirley Agnes Wolz				
4a. Facility Name (if not institution, give street and number) 9507 Vance Place		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 577-40-1114		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.
Usual Residence of Decedent				
10a. State MD	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 9507 Vance Place		10f. Zip Code 20901		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Herbert Cornelius Milstead		18. Mother's Name (First, Middle, Maiden Surname) Agnes Susan Hurst		
19a. Informant's Name/Relationship (Type, Print) Charles T. Wolz/husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 Vance Place Silver Spring, MD 20901		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey Crematory 09/03/11		Date
21. Signature of Funeral Service Licensee ► Beverly L. Heckrotte		22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029		20c. Location - City or Town, State Woodbine, MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death 12 months
<p>a. Colorectal Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D54378		29d. Date signed (Month, Day, Year) September 1, 2011
29b. Signature and title of certifier ► Cheryl A. Aylesworth, M.D.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl A. Aylesworth, M.D. 2730 University Blvd. W. #400 Wheaton, MD 20902				
31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature Seneca D. Parker		

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28172

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM PM	
Regina L. Williams		August 28 2011		1342 M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
NorthWest Hospital		Randallstown		Baltimore	
5. Social Security Number 214-58-9635		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) 60 Yrs.		If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 28 1951	
Usual Residence of Decedent MD		10a. State MD		10b. County Baltimore	
10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 3215 Windsor Blvd.		10f. Zip Code 21207		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A		16b. Kind of Business Industry Clerk U.S.P.S.	
17. Father's Name (First, Middle, Last) Wilmond Patrick Tucker, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Hanah Lea Venable			
19a. Informant's Name/Relationship (Type, Print) Thomas Williams-Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 Windsor Blvd. Baltimore, MD 21207			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemt		Date 9/3/2011	20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee ► [Signature]		22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Hypertensive Cardiovascular Disease (or as a consequence of):			
		b. Severe Pulmonary Hypertension (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Sleep Apnea Chronic Obstructive Pulmonary Disease		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► [Signature]		29c. License number H 53088	29d. Date signed (Month, Day, Year) August 28, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Galado 1838 Greene Tree Road #135 Baltimore Maryland 21208		31. Date filed (Month, Day, Year) SEP 06 2011		32. Registrar's Signature J. Parker	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28173

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death Hour:Minute AM/PM
Willie L. Wilson	08/28/11	05:30 M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Future Care Homewood	Baltimore, Md.	N/A

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/16/1914	9. Birthplace (State or Foreign Country) N.C.
---------------------------	--	---	---	--------------------------------	---	--

Usual Residence of Decedent

10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 2720 E. Oliver St.	10f. Zip Code 21213	10g. Citizen of What Country? USA
--	------------------------	--------------------------------------

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Black	14. Race - American Indian, Black, White, etc.
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A	16b. Kind of Business/Industry Assembly Worker
--	--	---

17. Father's Name (First, Middle, Last) Claude Green	18. Mother's Name (First, Middle, Maiden Surname) Mary Green
---	---

19a. Informant's Name/Relationship (Type, Print) Janel McGill-GrandDaughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2720 E. Oliver St. Baltimore, MD 21213
--	---

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemt.	Date 9/3/2011	20c. Location - City or Town, State Baltimore, MD
---	---	------------------	--

21. Signature of Funeral Service Licensee ► BN Cljt	22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <i>Cerebrovascular Accident</i> Due to (or as a consequence of):	
b. <i>Hypertension</i> Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. /	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
---	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	---

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier ► D. Salvi	29c. License number D17537	29d. Date signed (Month, Day, Year) 8-29-11
--	---	-------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANSHAN S. SALVI MD 6821 Reisterstown Rd, Baltimore 21217
---

31. Date filed (Month, Day, Year) SEP 06 2011	32. Registrar's Signature J. J. Hayes
--	--

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

1- For State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

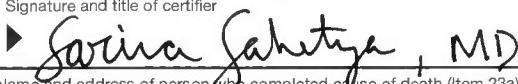
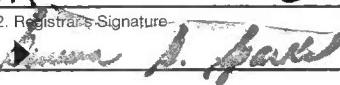
## Certificate of Death

Reg. No.

2011 28174

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<b>ANDREA WALKER</b>		Month Day Year		1432 M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<b>The Johns Hopkins Hospital</b>		<b>Baltimore City</b>		<b>N/A</b>
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/3/1975</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>VA</b>		
10a. State <b>D.C.</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>D.C.</b>		
10e. Street and Number <b>1937 Summit Place</b>		10f. Zip Code <b>20002</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4 yrs.</b>	16b. Kind of Business Industry <b>SalesForce</b>	
17. Father's Name (First, Middle, Last) <b>Roy Taylor Walker</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley Grimmett</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Shirley walker-Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1937 Summit Place NE Washington, DC 20002</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemt.</b>	Date <b>8/30/2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H 1101 E. North Ave. Baltimore, MD 21202</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <b>Respiratory Failure</b> Due to (or as a consequence of):				
b. <b>Hypoxemia</b> Due to (or as a consequence of):				
c. <b>Tumor invasion of airways</b> Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 26, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SARINA SAHETYA</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		
		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 28175

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Elizabeth Elseroad Wright</b>				2. Date of Death Month Day Year <b>August 31, 2011</b>	3. Time of Death 11:14 AM
4a. Facility Name (if not institution, give street and number) <b>4706 Valley View Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>	
4c. County of Death <b>N/A</b>					

Funeral  
Director

5. Social Security Number <b>213-28-4686</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month Day Year <b>08-21-1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
---	--	--	---	---------------------------	--------------------------	---	---

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

10a. State <b>Maryland</b>		10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number <b>4706 Valley View Avenue</b>			10f. Zip Code <b>21206</b>			10g. Citizen of What Country? <b>USA</b>

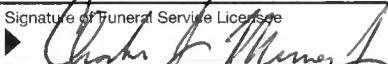
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Telephone Operator</b>	16b. Kind of Business Industry <b>Communications</b>
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17. Father's Name (First, Middle, Last) <b>Louis G. Elseroad</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy V. Garber</b>
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19a. Informant's Name/Relationship (Type, Print) <b>Mr. Brian L. Pearson - Nephew</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4706 Valley View Avenue Baltimore, Maryland 21206</b>
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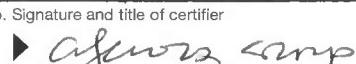
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Thomas Cemetery</b>	Date <b>09-03-2011</b>	20c. Location - City or Town, State <b>Owings Mills, Maryland</b>
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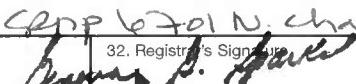
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>Leonard J. Ruck, Inc.</b>	5305 Harford Road <b>Baltimore, MD 21214</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>2006</b>
a. <i>Colon Cancer &amp; Lung metastasis</i> Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Diabetes mellitus</i> <i>Hypertension</i> <i>Hyperlipidemia</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29b. Signature and title of certifier 	29c. License number <b>R125808</b>	29d. Date signed (Month, Day, Year) <b>8/31/2011</b>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anne Lewis, CENP 6701 N. Charles St. #6105, Baltimore, MD 21204</b>	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature 
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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28176  
Reg. No.

1 - For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month AUGUST Day 28, Year 2011		3. Time of Death 9:52 A M
<i>Benjamin A. Wolfer</i>				
4a. Facility Name (if not institution, give street and number) <b>18 STONEGATE COURT</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>067-16-2637</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month Day Year) <b>10/17/1921</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>18 STONEGATE COURT</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DENTAL SURGEON</b>		16b. Kind of Business Industry <b>DENTISTRY</b>
17. Father's Name (First, Middle, Last) <b>SAMUEL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>WOLFER JENNY</b>		UNKNOWN
19a. Informant's Name/Relationship (Type, Print) <b>MURIEL WOLFER/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 STONEGATE COURT, BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW MONTEFIORE CEM.</b>		Date <b>09/02/2011</b>
20c. Location - City or Town, State <b>PINELAWN, NY</b>				
21. Signature of Funeral Service Licensee <i>Scott M. Cuttler</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
24a. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		24b. Describe how injury occurred		
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
25. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		26. Date of injury (Month, Day, Year) 27b. Time of injury M		
27c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>Moyer Gorbaty DO</i>		29c. License number <b>027938</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Moyer Gorbaty and 5401 Old Court Road Randallstown, MD 21133</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature <i>J. Powell</i>		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

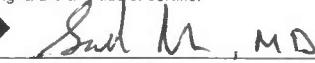
**Certificate of Death**

Reg. No.

2011 28177

3. Time of Death

Month Day Year  
August 31 2011 6:38 PM

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Clarence Wells</b>				2. Date of Death Month Day Year August 31 2011		3. Time of Death 6:38 PM			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death			
Funeral Director		5. Social Security Number <b>227-12-4795</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates: <b>WWII</b>	8. Date of Birth (Month, Day, Year) <b>3-9-1924</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>				
To Be Completed by Funeral Director		10a. State <b>MD</b>				10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Catonsville</b>			
		10e. Street and Number <b>216 Oak Forest Avenue</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>			
Physician /Medical Examiner		11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lithographer</b>		16b. Kind of Business/Industry <b>Dept. of Navy</b>					
		17. Father's Name (First, Middle, Last) <b>Clarence Wells</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lilian Litchford</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Clarence W. Wells/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14951 London Lane Bowie, MD 20715</b>						
		20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>9-2-2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>			
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Kaczorowski Funeral Home, PA <b>1201 Dundalk Avenue Baltimore, MD 21222</b>						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>									
		Approximate Interval Between Onset and Death <b>12 hours</b>									
		a. Due to (or as a consequence of): <b>Sepsis</b>									
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
		23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>									
		24a. Was an autopsy performed? <b>1 Yes 2 No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
		25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
		27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>10-10-2011</b>	28b. Time of Injury M <b>1 Yes 2 No</b>	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		29a. Certifier (Check only one) <b>1 Certifying Physician 2 Medical Examiner</b>		29f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29b. Signature and title of certifier 		29c. License number <b>RES - 000</b>		29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Satish Misra 4940 Eastern Avenue, Cardiac ICU, Baltimore, MD 21224</b>									
		31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be called at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28178

## Certificate of Death

Reg. No.

1- For  
State  
Registrar**Physician/  
Medical  
Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certificate: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>Rosalie Young</b>	2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2011</b>	3. Time of Death <b>6:404 M</b>		
4a. Facility Name (if not institution, give street and number) <b>Seasons Hospice Northwest</b>	4b. City, Town, or Location of Death <b>Randallstown</b>	4c. County of Death <b>Baltimore</b>		
5. Social Security Number <b>218-18-9570</b>	6. Sex <b>1 ♂ M 2 ♀ F</b>	7. Age (In yrs. last birthday) <b>89 Yrs.</b>		
8. Date of Birth (Month, Day, Year) <b>July 14, 1922</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	10d. Inside City Limits <b>1 Yes 2 No</b>		
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Owings Mills, MD</b>		
10e. Street and Number <b>900 Red Brook Blvd</b>	10f. Zip Code <b>21117</b>	10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>	16b. Kind of Business/Industry <b>New York City</b>		
17. Father's Name (First, Middle, Last) <b>Ulysses S. Johnson</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Arnett</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Dar Shird</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>900 Red Brook Blvd Owings Mills, MD 21117</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus</b>	20c. Date <b>9/3/2011</b>		
21. Signature of Funeral Service Licensee <b>► B. Shird, Funeral Dir</b>	22. Name and Address of Facility <b>Howell Funeral Home 4600 Liberty Heights Ave, Balt. MD</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death			
a. <b>end-stage dementia</b> Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE:				
23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>	23c. If yes, outcome of pregnancy <b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
		24a. Was an autopsy performed? <b>1 Yes 2 No</b>		
		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>	26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> <b>In-Patient Hospice</b>			
27. Manner of Death <b>1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				
29b. Signature and title of certifier <b>► N.S. Rajapakse, M.D.</b>	29c. License number <b>DO057465</b>	29d. Date signed (Month, Day, Year) <b>9/1/11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N.S. Rajapakse, M.D. 2835 Smith Av S 203 Baltimore MD 21209</b>				
31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>	32. Registrar's Signature <b>Leanne S. Parks</b>			

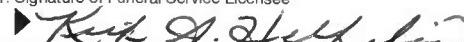
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28179

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BIRD J. ALLENDER</b>							2. Date of Death Month Day Year <b>AUGUST 09, 2011</b>	3. Time of Death 5:30 A M
	4a. Facility Name (if not institution, give street and number) <b>CHESTERTOWN NURSING AND REHABILITATION</b>				4b. City, Town, or Location of Death <b>CHESTERTOWN</b>			4c. County of Death <b>KENT</b>	
Funeral Director	5. Social Security Number <b>705-07-4971</b>		6. Sex <input checked="" type="checkbox"/> XM <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>103</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/15/1907</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	10a. State <b>MD</b>		10b. County <b>QUEEN ANNE'S</b>		10c. City, Town or Location <b>CHESTERTOWN</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>217 FEY ROAD</b>				10f. Zip Code <b>21620</b>			10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>			16b. Kind of Business Industry <b>ACCOUNTING AUDITOR</b>	
	17. Father's Name (First, Middle, Last) <b>PAUL BATEMAN ALLENDER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA ETHEL JACQUETTE</b>				
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ETHEL CUNNINGHAM / NIECE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8579 CAMP ROAD CHESTERTOWN, MARYLAND 21620</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESLEY CHAPEL CEMETERY</b>			Date <b>8-13-2011</b>	20c. Location - City or Town, State <b>ROCK HALL, MD</b>
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A.</b> <b>130 SPEER ROAD CHESTERTOWN, MARYLAND 21620</b>				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <b>Profound Debility</b>			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. Due to (or as a consequence of):					
23d. Due to (or as a consequence of):				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
23f. Due to (or as a consequence of):				23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
24. IF FEMALE: 24a. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				24b. Date of delivery Month Day Year <b>L</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <b>Natural</b> <input type="checkbox"/> Pending Investigation <b>Accident</b> <input type="checkbox"/> Could not be determined <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/>		
28a. Date of injury (Month, Day, Year)				28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>D23889</b>			29d. Date signed (Month, Day, Year) <b>8/9/11</b>		
29b. Signature and title of certifier 									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John C. ARRABAL JR. M.D. 223 High Street, Chestertown, Md 21620</b>									
31. Date filed (Month, Day, Year) <b>AUG 10 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

2 D

m/s

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28180

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit one.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death	
		RACHEL E. ALEXANDER						Month AUGUST Day 17 Year 2011		04:45 AM	
		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
		CALVERT MANOR HEALTHCARE CENTER			RISING SUN			CECIL			
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign)			
		218-03-6464	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	93 Yrs.	Months	Days	OCT. 28, 1917	NORTH EAST MARYLAND			
		Usual Residence of Decedent						10d. Inside City Limits			
		MARYLAND	10b. County CECIL	10c. City, Town or Location RISING SUN						1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street and Number 1881 TELEGRAPH ROAD			10f. Zip Code 21911			10g. Citizen of What Country? UNITED STATES			
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: WHITE			
		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry			
		Elementary/Secondary (0-12) 12			College (1-4 or 5+) CAFETERIA WORKER			PUBLIC SCHOOLS			
		17. Father's Name (First, Middle, Last) JAMES DUFFY REYNOLDS			18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH C. FERGUSON						
		19a. Informant's Name/Relationship (Type, Print) ARLYNE A. WILES / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 EAST DRIVE, RISING SUN, MARYLAND 21911						
		20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, cemetery or other place) NORTH EAST UNITED METHODIST CEMETERY			AUGUST 20, 2011	20c. Location - City or Town, State		
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)							NORTH EAST, MARYLAND		
		21. Signature of Funeral Service Licensee			22. Name and Address of Facility CROUCH FUNERAL HOME, P.A.			127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		Immediate Cause (Final disease or condition resulting in death)									
		<p>a. <i>Dementia</i>    Due to (or as a consequence of):  <i>Hypertension</i>    Due to (or as a consequence of):</p> <p>b. _____    Due to (or as a consequence of):</p> <p>c. _____    Due to (or as a consequence of):</p> <p>d. _____</p>									
		Approximate Interval Between Onset and Death <i>many years</i>									
		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
		<p><i>Diabetes Mellitus</i></p> <p>23c. If yes, outcome of pregnancy</p> <p>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy    4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____    9 <input type="checkbox"/> Unknown</p>									
		23d. Date of delivery									
		<p>Month Day Year</p>									
		23e. Did tobacco use contribute to the cause of death?									
		<p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p>									
		24a. Was an autopsy performed?									
		<p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>									
		25. Was case referred to medical examiner?									
		<p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>									
		26. Place of Death (Check only one)									
		27. Manner of Death									
		<p>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation    2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined    3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide    4 <input type="checkbox"/> Homicide</p>									
		28a. Date of injury (Month, Day, Year)									
		28b. Time of injury									
		<p>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28c. Injury at work?</p>									
		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier <i>Nell E. Latson</i>									
		29c. License number 00055354									
		29d. Date signed (Month, Day, Year) 08/17/11									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELL E. LATSON, M.D. 101 COLONIAL Way, Rising Sun, MD 21911									
		31. Date filed (Month, Day, Year) AUG 18 2011									
		32. Registrar's Signature <i>James J. Sparks</i>									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N

2011 2818

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arline Spencer Ballard</b>							2. Date of Death Month Day Year <b>August 18 2011</b>	3. Time of Death <b>10:30 AM</b>
	4a. Facility Name (if not institution, give street and number) <b>St. Mary's Nursing Center</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>			4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>577-22-5772</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>100</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/06/1910</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>St. Mary's</b>				10c. City, Town or Location <b>Leonardtown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>28610 Point Lookout Road</b>				10f. Zip Code <b>20650</b>		10g. Citizen of What Country? <b>U S A</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Librarian</b>			16b. Kind of Business Industry <b>Education</b>		
17. Father's Name (First, Middle, Last) <b>William Warren Spencer</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Myra Leahy</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Susan Kreckman/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28610 Point Lookout Rd, Leonardtown, MD 20650</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brinsfield-EcholsCrem</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>M00817</b>			Date <b>08/20/2011</b>	20c. Location - City or Town, State <b>Charlotte Hall, MD</b>	
21. Signature of Funeral Service Licensee <b>Brinsfield-Echols</b>				22. Name and Address of Facility <b>Brinsfield-Echols Funeral Home, P.A.</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					Approximate Interval Between Onset and Death <b>3 weeks</b>
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of): <b>Cerebral Detoxication</b></p> <p>b. Due to (or as a consequence of): <b>ASCVD</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <b>Natural</b> <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>D0600506</b>					
29b. Signature and title of certifier <b>Evan W. Bentz Jr.</b>				29d. Date signed (Month, Day, Year) <b>8/19/11</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>28170 Old Village Rd, Mechanicsville, MD 20659</b>									
31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>				32. Registrar's Signature <b>Jeanne J. Parker</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #17 Per EH C947 1/16/2014 Th

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28182

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

1. Decedent's Name (First, Middle, Last) <b>Lorraine Landers Brown</b>				2. Date of Death <b>August 14, 2011</b>	3. Time of Death <b>1:00 P M</b>
4a. Facility Name (if not institution, give street and number) <b>Bradford Oaks Nursing Facility</b>				4b. City, Town, or Location of Death <b>Clinton</b>	
				4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>077-24-3081</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
8. Date of Birth <b>09/03/1918</b>				9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Upper Marlboro</b>					
10e. Street and Number <b>10207 Quince Apple Court</b>			10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Psychiatric Aide</b>		16b. Kind of Business Industry <b>Hospital</b>	
17. Father's Name (First, Middle, Last) <b>Hodford Rozier Sedgwick N. Landers</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Parralee Edith Dyson</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Hodford Brown III / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10207 Quince Apple Court Upper Marlboro, MD 20772</b>		
20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kalas Crematory</b>		Date <b>8/16/2011</b>	20c. Location - City or Town, State <b>Edgewater, Maryland</b>
21. Signature of Funeral Service Licensee <b>J.P. Kelly</b>			22. Name and Address of Facility <b>George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745</b>		

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Due to (or as a consequence of):  <i>Cardiomyopathy</i> <i>Valvular heart disease severe</i> <i>chronic atrial fibrillation.</i> <i>chronic kidney disease</i>		Approximate Interval Between Onset and Death <b>&gt; 5 years</b>
				<b>&gt; 5 years</b>
				<b>&gt; 3 years</b>
				<b>&gt; 3 years -</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>osteoarthritis -</i> <i>history of transient ischemic attacks -</i>				23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home, farm, street, factory, office building, etc. (Specify)</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>At home, farm, street, factory, office building, etc. (Specify)</b>	
29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D0042049</b>		29d. Date signed (Month, Day, Year) <b>August 15<sup>th</sup>, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alain G. Champaloux MD - Upper Marlboro MD 20772</b>				
31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature <b>Renata S. Parks</b>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28183

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)  
rm

Medical Certificate To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Frances E. Brown</b>			2. Date of Death Month <b>August</b> Day <b>17</b> Year <b>2011</b>		3. Time of Death <b>4:30 AM</b>
4a. Facility Name (if not institution, give street and number) <b>Chester River Manor</b>			4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>
5. Social Security Number <b>218-20-8224</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
10a. State <b>MD</b>		10b. County <b>Queen Anne</b>	10c. City, Town or Location <b>Chestertown</b>	8. Date of Birth (Month, Day, Year) <b>10/4/1926</b>	
10e. Street and Number <b>305 Pine Tree RD</b>			10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Packer</b>		16b. Kind of Business Industry <b>Vita Foods</b>	
17. Father's Name (First, Middle, Last) <b>Leonard</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Hynson Madeline Hynson</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Leonard Bratcher</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7911 Della Rosa Court Pasadena, MD 21122</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Daniel Cemetery</b>		Date <b>8/23/2011</b>	20c. Location - City or Town, State <b>Barclay, MD</b>
21. Signature of Funeral Service Licensee <b>John A. Prince</b>			22. Name and Address of Facility <b>855 High Street Chestertown, MD 21620 Bennie Smith Funeral Home</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. <b>FAILURE TO THRIVE</b> Due to (or as a consequence of):</p> <p>b. <b>STAPHYLOCOCCAL BACTEREMIA</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>					
Approximate Interval Between Onset and Death <b>1 month</b> <b>2 months</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE, END STAGE</b> <b>NON-HODGKIN'S LYMPHOMA</b> <b>CONGESTIVE HEART FAILURE</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Helen A. Noble MD</b>			
		29c. License number <b>DOO41587</b>		29d. Date signed (Month, Day, Year) <b>8/17/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen A. Noble, M.D., 122 Speer RD Suite 5 Chestertown, MD 21620</b>					
31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature <b>Bennie S. Parker</b>			

ORIGINAL

Travis Bielaski

11-06417

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28184

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0915 hrs
--	------------------------------------	------------------------------

Travis William Bielaski

August 26, 2011

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Chesapeake Bay Bridge under WB span of Route 50	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
---	---	-------------------------------------

5. Social Security Number 213-98-4589	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 06/12/1974	9. Birthplace (State or Foreign Country) Wash DC
--	--	---	---	---	---

Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Catonsville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
---	--	--	--	--	--

10e. Street and Number 26 Somerset Road	10f. Zip Code 21228	10g. Citizen of What Country? United States
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Real Estate Agent
--	---	---

17. Father's Name (First, Middle, Last) Thomas M. Bielaski	18 Mother's Name (First, Middle, Maiden Surname) Sally A. Perry
---	--

19a. Informant's Name/Relationship (Type, Print) Laura R. Bielaski - wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Somerset Road Catonsville, MD 21228
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Ardent Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory	Date 08/29/2011	20c. Location - City or Town, State Hanover, MD
--	--	--------------------	--

21. Signature of Funeral Service Licensee per DVR Sherri Collins- Witzke-M01044	22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043
--	--

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. <u>Drowning and multiple injuries</u> Due to (or as a consequence of):
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):
--	--

c. _____ Due to (or as a consequence of):
--

d. _____
----------

<input checked="" type="checkbox"/> UNPENDED	# AMENDED 21 Per FH G919 9/01/2011 JH 23a, 27, 28a-f, per me, g921 11-18-11 sm
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

_____	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 8-26-11	28b. Time of Injury fd 8:52 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <u>subject precipitated from bridge</u>
--	--	-----------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	bridge	28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>Chesapeake Bay Bridge under w/b span of route 50</u>
---	--------	---

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
---

29b. Signature and title of certifier <u>Theodore M. King, Jr., MD.</u>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 27, 2011
--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) AUG 29 2011	32. Registrar's Signature <u>Anna B. Parker</u>
--	--

file

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28185

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Avery Monique Bechtel

2. Date of Death

Month Day Year  
August 15 2011

3. Time of Death

10:01 AM

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

219-51-4408

6. Sex

M  F

7. Age (In yrs. last birthday)

13

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 27, 1998

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

Yes  2  No

10e. Street and Number

220 Dodson Avenue

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

student

16b. Kind of Business Industry

public school

17. Father's Name (First, Middle, Last)

Ryan Swann

18. Mother's Name (First, Middle, Maiden Surname)

Angela Marie Bechtel

19a. Informant's Name/Relationship (Type, Print)

Angela M. Bechtel mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

220 Dodson Avenue, St. Michaels, MD 21663

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenlawn Cemetery

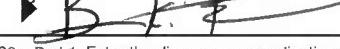
Date

8/22/11

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Edema

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

b. Pedestrian Struck

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No

9  Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy

Pregnant at time of death  Other (Specify)

9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

24a. Was an autopsy performed?

Yes  No

24b. Were autopsy findings available prior to completion of cause of death?

Yes  No

25. Was case referred to medical examiner?

Yes  No

Hospital:

1  Inpatient

2  ER/Outpatient

3  DOA

Other:

4  Nursing Home

5  Residence

6  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1  Natural

5  Pending Investigation

2  Accident

6  Could not be determined

3  Suicide

7  Determined

4  Homicide

28a. Date of injury (Month, Day, Year)

August 12, 2011

28b. Time of injury

9:30 PM

28c. Injury at work?

1  Yes

2  No

28d. Describe how injury occurred

Pedestrian Struck

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 322 at Marlboro Rd

Easton, MD

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 Elizabeth Alexis Charnovich MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 15 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Alexis Charnovich, MD 600 North Wolfe Street Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 19 2011

32. Registrar's Signature

 Anna J. Ford

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 perf FCHD 1M 08/29/11

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28186

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Estelle E. Blassingame</b>				2. Date of Death Month <b>August</b>	Day <b>15</b> , 2011	Year <b>8:15 P.M.</b>	
4a. Facility Name (if not institution, give street and number) <b>Kline Hospice House</b>				4b. City, Town, or Location of Death <b>Mt. Airy</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>462-52-9195</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar. 15, 1923</b>	9. Birthplace (State or Foreign Country) <b>Texas</b>
Usual Residence of Decedent  10a. State <b>Maryland</b>				10b. County <b>Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10c. City, Town or Location  <b>Mt. Airy</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status  <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc.  Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Seconday (0-12) 11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>College (1-4 or 5+)</b>		16b. Kind of Business Industry  <b>Seamstress</b>			Clothing Manufacturing
17. Father's Name (First, Middle, Last)  <b>Louis W. Lester</b>				18. Mother's Name (First, Middle, Maiden Surname)  <b>Virgie Lee Matthews</b>			
19a. Informant's Name/Relationship (Type, Print)  <b>Linda Cerrone / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  <b>13535 Old Annapolis Road Mt. Airy, Maryland 21771</b>			
20a. Method of Disposition  <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)  <b>Memorial Park Cem.</b>		Date <b>August</b>	20c. Location - City or Town, State  <b>Amarillo, Texas</b>		
21. Signature of Funeral Service Licensee  		22. Name and Address of Facility  <b>Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771</b>					

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of):  <b>Congestive Heart Failure</b>				Approximate Interval Between Onset and Death <b>Years</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):					
		23d. Due to (or as a consequence of):					
		23e. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy  <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)  Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)  <b>Hospice House</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number  <b>D68104</b>				29d. Date signed (Month, Day, Year)  <b>8/16/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Eric Bush MD, 516 Trail Ave, Frederick, MD 21702</b>		31. Date filed (Month, Day, Year)  <b>AUG 17 2011</b>				32. Registrar's Signature  <b>Debbie L. Parker</b>	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a and 26 per med cert G919 9/1/11

State of Maryland / Department of Health and Mental Hygiene

2011 28187

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donald Lee Booth</b>						2. Date of Death Month Day Year <b>08 21 2011</b>	3. Time of Death <b>8:30p M</b>		
	4a. Facility Name (If not institution, give street and number) <b>17416 Pompey Smash Road</b>			4b. City, Town, or Location of Death <b>Frostburg</b>			4c. County of Death <b>Allegany</b>			
Funeral Director	5. Social Security Number <b>213-40-2874</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>08 05 1941</b>	If Under 24 Hrs. Hours Min.	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	10a. State <b>MD</b>			10b. County <b>Allegany</b>			10c. City, Town or Location <b>Frostburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>17416 Pompey Smash Road</b>			10f. Zip Code <b>21532</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1958 1961</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4or 5+) Truck Mechanic</b>			16b. Kind of Business/Industry <b>Auto</b>			
	17. Father's Name (First, Middle, Last) <b>William Henry Booth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maryland Skidmore Booth</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Diana Booth Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17416 Pompey Smash Rd Frostburg, MD 21532</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Cumberland Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>			Date <b>08-23-2011</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>		
	21. Signature of Funeral Service Licensee <b>► Alan J. Sowers m0547</b>			22. Name and Address of Facility <b>Sowers Funeral Home, P.A. 60 W. Main St., Frostburg, MD 21532</b>						
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>COPD</b>								Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CAD</b> <b>HTN</b>									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								IF FEMALE: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>2087737</b>							
	29b. Signature and title of certifier <b>► Thomas A. Bustoph CRNP</b>		29d. Date signed (Month, Day, Year) <b>8/23/11</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas A. Bustoph CRNP 60 Memorial Ave Cumberland, MD</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>		32. Registrar's Signature <b>James S. Jones</b>							

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trait

#242 + 26

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28188

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Jeanette Alice Cooke</b>						2. Date of Death Month 8 Day 17 Year 2011		3. Time of Death 12:11AM												
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>3 Washington St.</b>			4b. City, Town, or Location of Death <b>Berlin</b>			4c. County of Death <b>Worcester</b>														
To Be Completed by Funeral Director		5. Social Security Number <b>213-50-2933</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>9/17/1917</b>	9. Birthplace (State or Foreign Country) <b>MI</b>													
		Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Worcester</b> 10c. City, Town or Location <b>Berlin</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
		10e. Street and Number <b>3 Washington St.</b>			10f. Zip Code <b>21811</b>			10g. Citizen of What Country? <b>USA</b>														
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Native American</b>													
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business Industry <b>Own Home</b>														
		17. Father's Name (First, Middle, Last) <b>James St. Arnold</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Isabelle Loonsfoot</b>																	
		19a. Informant's Name/Relationship (Type, Print) <b>Gina N. Ashton / daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Washington St., Berlin, MD 21811</b>																	
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>First State Crem.</b>		Date <b>8/18/2011</b>	20c. Location - City or Town, State <b>Millsboro, DE</b>															
		21. Signature of Funeral Service Licensee <b>► Jim MacLeod</b>		22. Name and Address of Facility <b>Burbage Funeral Home 108 William St., Berlin, MD 21811</b>																		
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 month</b>												
		<table border="1"> <tr> <td>a.</td> <td>Due to (or as a consequence of): <b>End Stage Congestive Heart Failure</b></td> <td></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): <b>Hypertension</b></td> <td><b>4 years</b></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								a.	Due to (or as a consequence of): <b>End Stage Congestive Heart Failure</b>		b.	Due to (or as a consequence of): <b>Hypertension</b>	<b>4 years</b>	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):		
a.	Due to (or as a consequence of): <b>End Stage Congestive Heart Failure</b>																					
b.	Due to (or as a consequence of): <b>Hypertension</b>	<b>4 years</b>																				
c.	Due to (or as a consequence of):																					
d.	Due to (or as a consequence of):																					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year															
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hx CVA CAD</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>H0056241</b>			29d. Date signed (Month, Day, Year) <b>08-17-11</b>															
		29b. Signature and title of certifier <b>► Deborah Conway, DO</b>		29c. License number <b>H0056241</b>			29d. Date signed (Month, Day, Year) <b>08-17-11</b>															
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deborah Conway, DO 10344 OH Ocean City Blvd Berlin, MD 21811</b>		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>			32. Registrar's Signature <b>Deborah J. Park</b>															

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28189

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NANCY LEE CROSS

2. Date of Death

Month AUGUST Day 12, Year 2011

3. Time of Death

12:13 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

CHESTER RIVER HOSPITAL CENTER

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

5. Social Security Number

216-32-9624

6. Sex

 M  F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Hours

(Month, Day, Year)

Min.

1-20-1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

 Yes  No

10e. Street and Number

206 WALDO DRIVE

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

 Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

 Yes  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Seconday (0-12)  
1216a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

HOME MAKER

16b. Kind of Business Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE HOLZSHU ROEDER

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY VIRGINIA ELMER

19a. Informant's Name/Relationship (Type, Print)

NANCY M. CROSS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 N. WATER ST. APT. #7 CHESTERTOWN, MD 21620

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

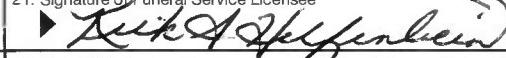
DRUID RIDGE CEMETERY

Date

20c. Location - City or Town, State

8-17-2011 PIKESVILLE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.  
130 SPEER RD. CHESTERTOWN, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death minutes

CORONARY ARTERY DISEASE

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBESITY

ANXIETY DISORDER  
HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown24a. Was an autopsy performed?  
1  Yes 2  No  
24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M  
1  Yes 2  No28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0041587

29d. Date signed (Month, Day, Year)

8/15/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A Noble MD 122 Speer Road Chestertown, MD 21620

31. Date filed (Month, Day, Year)

AUG 15 2011

32. Registrar's Signature



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28190

1 For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036 *Hand*  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 1  Yes 2  No  
 9  Unknown23c. If yes, outcome of pregnancy  
 1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
 4  Pregnant at time of death 5  Other (Specify) \_\_\_\_\_  
 9  Unknown23d. Date of delivery  
 Month Day YearPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
*Congestive heart failure, cardiac arrhythmia, ischemic heart disease,  
 Valvular heart disease*23e. Did tobacco use contribute to the cause of death?  
 1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
 1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify) *Hospice House*

27. Manner of Death

1  Natural 5  Pending Investigation  
 2  Accident 6  Could not be determined  
 3  Suicide  
 4  Homicide28a. Date of injury  
 (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 (Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier  
*J. Seymour MD*

29c. License number

*D57860*

29d. Date signed (Month, Day, Year)

*August 18, 2011*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*J. Seymour MD 508 Oldswild Avenue, Easton, MD 21601*

31. Date filed (Month, Day, Year)

*AUG 18 2011*

32. Registrar's Signature

*Suzanne P. Jones*State  
Registrar

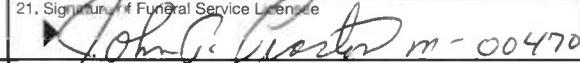
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28191

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE VIRGINIA CLARK</b>					2. Date of Death Month Day Year <b>AUGUST 15, 2011</b>	3. Time of Death 09:00A M
	4a. Facility Name (If not institution, give street and number) <b>2201 Briggs Road</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>217-34-0029</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 17 1932</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent <b>Maryland Montgomery</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>
	10e. Street and Number <b>2201 Briggs Road</b>			10f. Zip Code <b>20906</b>			10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 Bus Driver</b>			16b. Kind of Business/Industry <b>Public Schools</b>	
17. Father's Name (First, Middle, Last) <b>Calvin H. Ray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma N. Burriss</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Connie A. Kimble / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2201 Briggs Road, Silver Spring, Md. 20906</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington C.</b>		Date <b>8/19/11</b>	20c. Location - City or Town, State <b>Hyattsville, MD</b>		
21. Signature of Funeral Service Licensee  <b>John G. Lester m-00470</b>				22. Name and Address of Facility <b>Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Dementia</b>				Approximate Interval Between Onset and Death <b>2 years</b>			
b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D23124</b>		29d. Date signed (Month, Day, Year) <b>August 15, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis M. Hannon, M.D. 3300 Olney-Sandy Spring Rd., #330, Olney, Md. 20832</b>							
31. Date filed (Month, Day, Year) <b>AUG 17 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28192

1-For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1209 hrs
<b>Wayde Benjamin Dickerson</b>	August 14, 2011	

4a. Facility Name (if not institution, give street and number) <b>23731 Lands End Road</b>	4b. City, Town, or Location of Death <b>Chestertown</b>	4c. County of Death <b>Kent</b>
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**Funeral  
Director**

5. Social Security Number <b>212-80-1287</b>	6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>51</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) <b>10/30/1959</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
			Yrs.	Hours	Min.	

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

10a. State <b>MD</b>	10b. County <b>Kent</b>	10c. City, Town or Location <b>Chestertown</b>	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number <b>23731 Lands End Road</b>	10f. Zip Code <b>21620</b>	10g. Citizen of What Country? <b>United States</b>
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	14. Race - American Indian, Black, White, etc.
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Handyman</b>	16b. Kind of Business/Industry <b>Maintenance</b>
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17. Father's Name (First, Middle, Last) <b>Alfred Franklin Dickerson</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy R. Dickerson</b>
---	--

19a. Informant's Name/Relationship (Type, Print) <b>Nancy R. Dickerson / Mother</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>73781 Lands End Road Chestertown, Maryland 21620</b>
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation</b>	Date <b>08/15/2011</b>	20c. Location - City or Town, State <b>Stevensville, Maryland</b>
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensee <i>Kirk J. Helfenstein</i>	22. Name and Address of Facility <b>Fellows, Hlefenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Maryland 21620</b>
---	---

**Physician  
/Medical  
Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. <b>Gastrointestinal Hemorrhage</b> Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Chronic Alcoholism</b> Due to (or as a consequence of):
	c. Due to (or as a consequence of):
	d. Due to (or as a consequence of):

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED
-----------------------------------	----------------------------------

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	26. Place of Death (Check only one)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 15, 2011</b>
---	--	---

30. Name and address of person who completed cause of death (Item 23a) <b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
--

31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>	32. Registrar's Signature <i>Jane L. Jackson</i>
---	---

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

3

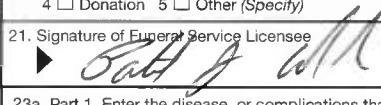
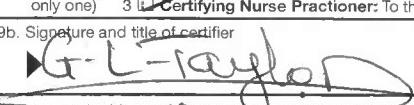
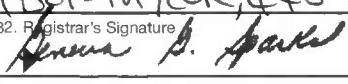
m

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28193  
Reg. No.

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>RODNEY H. FISK</b>		2. Date of Death Month 8 Day 12 Year 2011	3. Time of Death M 0315 M
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>880 Coachway</b>		4b. City, Town, or Location of Death <b>Annapolis</b>	
Funeral Director		5. Social Security Number <b>217-08-0340</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months Days Hours Min.
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>	
		10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>880 Coachway</b>		10f. Zip Code <b>21401</b>	10g. Citizen of What Country? <b>USA</b>
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>05</b>	16b. Kind of Business Industry <b>CEO, President</b>	Logistics Transportation
		17. Father's Name (First, Middle, Last) <b>Gordon Strachan Fisk</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Wilhelmina Larsen</b>	
		19a. Informant's Name/Relationship (Type, Print) <b>Deborah C. Fisk Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>880 Coachway Annapolis, MD 21401</b>	
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>	Date <b>08/14/2011</b>	20c. Location - City or Town, State <b>Glen Burnie, MD</b>
		21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>Hardesty Funeral Home P.A. Annapolis, MD 21401</b>	12 Ridgely Ave	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): <b>PANCREATIC CANCER</b> Approximate Interval Between Onset and Death: <b>MONTHS</b>			
Medical Certificate/ To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE:		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			
		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Sp			
		29c. License number <b>R118703</b>			
		29d. Date signed (Month, Day, Year) <b>8/12/2011</b>			
31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature 			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GENEVA LIGHTFOOT-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, MD 21401</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28194

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lawrence Melvin Foster</b>					2. Date of Death Month <b>August</b> Day <b>23</b> , Year <b>2011</b>	3. Time of Death <b>8:23 A M</b>
	4a. Facility Name (if not institution, give street and number) <b>45121 Hewitt Road</b>			4b. City, Town, or Location of Death <b>Callaway</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>223-42-0967</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1928</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>St. Mary's</b> 10c. City, Town or Location <b>Callaway</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>45121 Hewitt Road</b>			10f. Zip Code <b>20620</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>8</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>			16b. Kind of Business Industry <b>Livestock</b>
	17. Father's Name (First, Middle, Last) <b>Henry Nelson Foster</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel May Garrison</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Joyce B. Foster / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>45121 Hewitt Road Callaway, MD 20620</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Charles Mem. Gardens</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)	Date <b>8-27-11</b>	20c. Location - City or Town, State <b>Leonardtown, MD</b>	
	21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr.</b>			22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A.</b> <b>22955 Hollywood Road Leonardtown, MD 20650</b>			
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Cardiovascular Disease 5 yr</b>						
	Approximate Interval Between Onset and Death.						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic Obstructive Pulmonary Disease 15 yr</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9 Unknown</b>						
	23d. Date of delivery Month <b>Day</b> <b>Year</b>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <b>Rene E Grace, MD</b>						
	29c. License number <b>002259</b>						
	29d. Date signed (Month, Day, Year) <b>Aug. 24 2011</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rene E Grace, MD, FAAPP</b>						
	31. Date filed (Month, Day, Year) <b>AUG 26 2011</b>						
	32. Registrar's Signature <b>Rene A. Grace</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

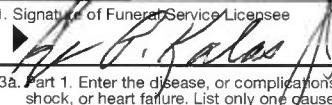
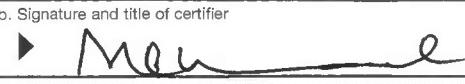
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28195

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Anne Gilbert				2. Date of Death Month August Day 13, 2011 Year	3. Time of Death 10:58 A M	
	4a. Facility Name (if not institution, give street and number) 325 Winslow Road		4b. City, Town, or Location of Death Oxon Hill		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 198-22-2666	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 10/06/1930	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Oxon Hill				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 325 Winslow Road			10f. Zip Code 20745		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher		16b. Kind of Business Industry Education		
	17. Father's Name (First, Middle, Last) Walter Folcik			18. Mother's Name (First, Middle, Maiden Surname) Victoria Szymanski			
	19a. Informant's Name/Relationship (Type, Print) Joseph C. Gilbert / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Winslow Road Oxon Hill, Maryland 20745			
Physician/ Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 8/16/2011	20c. Location - City or Town, State Edgewater, Maryland		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic lung cancer						
	a. Due to (or as a consequence of): Metastatic lung cancer						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. _____						
	Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year						
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease hypertension						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 						
	29c. License number D24020						
	29d. Date signed (Month, Day, Year) 8/15/2011						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOTILAL KAUL MD 4467 Old Branch Ave Temple Hills, MD 20748						
State Registrar	31. Date filed (Month, Day, Year) AUG 16 2011	32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28196

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death			3. Time of Death		
<b>Edna Virginia Gleaves</b>	Month	Day	Year	2055 P.M.		
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Death		
<b>Chester River Hospital Center</b>	<b>Chestertown</b>			<b>Kent</b>		
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
<b>215-20-0044</b>	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	<b>93 Yrs.</b>	Months	Days	(Month, Day, Year) <b>10 1 1917</b>	MD
Usual Residence of Decedent						
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits
MD	<b>Kent</b>	<b>Worton</b>				1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?
<b>25854 East Hill RD.</b>			<b>21678</b>			<b>USA</b>
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry	
Elementary/Secondary (0-12) <b>9th</b>	College (1-4 or 5+)	<b>Domestic Work</b>			<b>Private Family</b>	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)		
<b>James L. Wilson</b>				<b>Areba Hackett</b>		
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
<b>Alice Steward -Neice</b>			<b>25854 East Hill RD Worton, MD 21678</b>			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		<b>Mt. Zion U.M.</b>		<b>8/24/2011</b>	<b>Still Pond, MD</b>	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility				
<b>Harry J. Reese</b>		<b>Kenneth Walley Funeral Svc 1922 Forest Dr Annapolis, MD 21401</b>				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <b>INTRA ABDOMINAL HEMORRHAGE</b> Due to (or as a consequence of):	
b. _____ Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):	
d. _____	

IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
_____		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
_____		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one)
		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number	29d. Date signed (Month, Day, Year)
<b>Y</b>	<b>D0071130</b>	<b>AUGUST 16 2011</b>

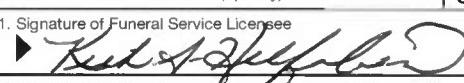
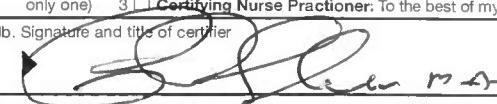
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
<b>Keri Jacobs 100 Brown ST CHESTERTOWN MD 21620</b>	
31. Date filed (Month, Day, Year)	32. Registrar's Signature
<b>AUG 19 2011</b>	<b>Suzanne S. Parker</b>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended#10a, b, 1 - For State 10c, d, e, f, M. S. Kent Co 8/23/Certificate of Death

2011 28197  
Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>JOHN LEE GILL</b>				2. Date of Death Month Day Year <b>AUGUST 10, 2011</b>	3. Time of Death <b>2:40 A M</b>
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>CHESTER RIVER MANOR</b>		4b. City, Town, or Location of Death <b>CHESTERTOWN</b>		4c. County of Death <b>KENT</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>218-16-7131</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b>8 Months 0 Days 0 Hours 0 Min.</b>	8. Date of Birth (Month, Day, Year) <b>09/17/1922</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
		Usual Residence of Decedent 10a. State <b>New York</b> <b>MD</b>		10b. County <b>New York</b> <b>QUEEN ANNE'S</b>		10c. City, Town or Location <b>New York</b> <b>CENTREVILLE</b>	
		10e. Street and Number <b>4 Peter Cooper Rd. Apt 1E</b> <b>222 MALLARD DRIVE</b>		10f. Zip Code <b>100010</b> <b>21617</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
		11. Marital Status <b>1 □ Never Married 2 □ Married</b> <b>3 X Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 □ No</b> If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No</b> Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>4</b> <b>FBI AGENT</b>		16b. Kind of Business Industry <b>LAW ENFORCEMENT</b>	
		17. Father's Name (First, Middle, Last) <b>CHARLES LEE GILL, JR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MABLE COPPAGE</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>EDWARD SMITH / BROTHER IN LAW</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>222 MALLARD DRIVE CENTREVILLE, MARYLAND 21617</b>			
Physician/ Medical Examiner		20a. Method of Disposition <b>1 □ Burial 2 X Cremation 3 □ Removal from State</b> <b>4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION</b>		Date <b>08/10/2011</b>	20c. Location - City or Town, State <b>STEVENSVILLE, MARYLAND</b>
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A.</b> <b>130 SPEER ROAD CHESTERTOWN, MARYLAND 21620</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		metastatic BRAIDEN CANCER		Approximate Interval Between Onset and Death <b>5 yrs</b>	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
				b. Due to (or as a consequence of):			
				c. Due to (or as a consequence of):			
				d. Due to (or as a consequence of):			
		IF FEMALE:		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) _____ 9 □ Unknown		23d. Date of delivery Month Day Year	
		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>NJD</i>				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown	
						24a. Was an autopsy performed? 1 □ Yes 2 □ No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
		25. Was case referred to medical examiner? 1 □ Yes 2 □ No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOD Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)			
		27. Manner of Death 1 □ Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier 		29c. License number <b>D3605-4</b>		29d. Date signed (Month, Day, Year) <b>8-10-11</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patrick J. Shanahan MD 130 Speer Rd Bldg B Chestertown MD 21620</b>					
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 11 2011</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

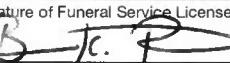
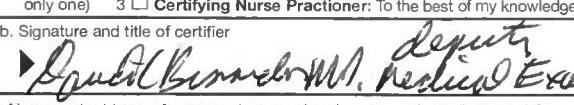
Certificate of Death

Reg. No.

2011 28198

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
James Hardy Jr.		Month August Day 14 2011 Year		1:26 a.m.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
2712 Wesley Church Road		Crapo		Dorchester	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	
578-72-1342		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	57 Yrs.		
10a. State		10b. County	10c. City, Town or Location		10d. Inside City Limits
MD		Dorchester	Crapo		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
2712 Wesley Church Road		21626		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1969-73		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry	
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 2		leader federal government	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
James Hardy		Josephine Savage			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Carolyn J. Hardy wife		2712 Wesley Church Road, Crapo, MD 21626			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Crematory of Delmarva		8/20/11	Delmar, DE
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613	
					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of):  <i>Atherosclerotic Coronary Vagular disease</i>		Approximate Interval Between Onset and Death <i>years</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):  <i>Hypercholesterolemia</i>		Years	
{		c. Due to (or as a consequence of):  <i>Hypertension</i>		Years	
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number		29d. Date signed (Month, Day, Year)	
29b. Signature and title of certifier 		040120		August 16, 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
David C. Brandon MD, 5500 Andover Hall Rd, Royal Oak, MD 21662					
31. Date filed (Month, Day, Year)		32. Registrar's Signature			
AUG 19 2011					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28199

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)

Ina Marie Higgs

2. Date of Death

Month Day Year  
August 20, 2011

3. Time of Death

2:35 P M

4a. Facility Name (if not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

578-70-4614

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
3-18-1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Avenue

10d. Inside City Limits

1  Yes  No

10e. Street and Number

23217 Colton Point Road

10f. Zip Code

20609

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Receptionist

16b. Kind of Business Industry

Printing

17. Father's Name (First, Middle, Last)

William Dove

18. Mother's Name (First, Middle, Maiden Surname)

Jane Colclough Jones

19a. Informant's Name/Relationship (Type, Print)

Katherine Higgs / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23217 Colton Point Road Avenue, MD 20609

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols

Date

08/26/2011 Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A. 22955 Hollywood Road Leonardtown, MD 20650

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

*ISCHEMIE HEART DISEASE*

*4 YEARS*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

*ATHEROSCLEROSIS*

b. Due to (or as a consequence of):

*HYPERTENSION*

*YEARS*

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*END STAGE RENAL DISEASE*

*HYPERTENSION*

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*► R. GIBSON B. ROBERT GIBSON*

29c. License number

*1064840*

29d. Date signed (Month, Day, Year)

*8/20/2011*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*BRUCE ROBERT GIBSON, 25500 POINT LOOKOUT RD LEONARDTOWN MD 20650*

31. Date filed (Month, Day, Year)

*AUG 26 2011*

32. Registrar's Signature

*Anna S. Gates*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28200

3. Time of Death

9:05 A M

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Pamela A. Hemingway

2. Date of Death

Month Day Year  
August 13 2011

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)  
St. Thomas Moore Nursing

4b. City, Town, or Location of Death  
Hyattsville

4c. County of Death  
Prince George's

Funeral  
Director

5. Social Security Number  
220-88-8456

6. Sex

F

7. Age (In yrs, last birthday)

49

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

Jan. 9, 1962

9. Birthplace (State or Foreign Country)

Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent  
10a. State  
VA  
10b. County  
Loudoun  
10c. City, Town or Location  
Leesburg

10e. Street and Number  
710 Clark Court #101  
10f. Zip Code  
20176  
10g. Citizen of What Country?  
U.S.A.

11. Marital Status  
1  Never Married 2  Married  
3  Widowed 4  Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Seconday (0-12) College (1-4 or 5+) 5+  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Handicapped  
16b. Kind of Business Industry  
Disabled

17. Father's Name (First, Middle, Last)  
Wilton Fones  
18. Mother's Name (First, Middle, Maiden Surname)  
Eunice Mcabee

19a. Informant's Name/Relationship (Type, Print)  
Vilma Escandon POA/  
Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
710 Clark Court #101 Leesburg, VA 20175  
20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)  
Metropolitan  
Date  
20c. Location - City or Town, State  
8/19/11 Alexandria, VA

21. Signature of Funeral Service Licensee  
► William J. McLean, Jr.  
22. Name and Address of Facility  
Loudoun Funeral Chapel  
158 Catoctin Cr. SE, Leesburg, VA 20175

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
{  
a. Due to (or as a consequence of):  
Altherosclerotic Cardiovascular Disease  
b. Due to (or as a consequence of):  
Respiratory Failure  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Approximate Interval Between Onset and Death

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown  
23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown  
23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
End Stage Renal Disease - Hemodialysis Dependent  
23e. Did tobacco use contribute to the cause of death?  
1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No  
24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?  
1  Yes 2  No  
Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA  
Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death  
1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide  
28a. Date of injury (Month, Day, Year)  
28b. Time of injury  
M  
28c. Injury at work?  
1  Yes 2  No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
only one  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
► R. V.  
29c. License number  
D0063681  
29d. Date signed (Month, Day, Year)  
8/14/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Ajay Kurup, MD, 1835 University Blvd. E. #208E, Hyattsville, MD 20783

31. Date filed (Month, Day, Year)  
SEP 01 2011  
32. Registrar's Signature  
Lorraine D. Johnson

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

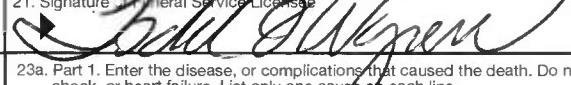
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28201

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Donna Kimber</b>					2. Date of Death Month <b>August</b> Day <b>9</b> Year <b>2011</b>	3. Time of Death 2:06 PM		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Frederick Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>572-91-4088</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Jan. 12, 1979</b>	9. Birthplace (State or Foreign Country) <b>California</b>		
		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>New Market</b>					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		10e. Street and Number <b>6954 Fair Lane</b>			10f. Zip Code <b>21774</b>		10g. Citizen of What Country? <b>United States</b>			
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>College (1-4 or 5+)</b> 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive</b>		16b. Kind of Business Industry <b>Banking</b>			
		17. Father's Name (First, Middle, Last) <b>Stephen R. Kimber</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Donna Brocato</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Jacob M. Galvas / Fiance</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6954 Fair Lane, New Market, Maryland 21774</b>					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Stauffer Crematory Inc.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>8/13/2011</b>		Date	20c. Location - City or Town, State <b>Frederick, Maryland.</b>		
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Stauffer Funeral Homes P. A.</b> <b>1621 Opossumtown Pike, Frederick, Maryland 21702</b>					
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, many leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 hour</b>	
Medical Certificate: To Be Completed by Physician/Medical Examiner		<p>a. <b>Hemorrhage</b> Due to (or as a consequence of):</p> <p>b. <b>Mucocidermoid Salivary Carcinoma</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0034714</b>		29d. Date signed (Month, Day, Year) <b>8/12/11</b>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>22 S. Greene St, Baltimore, MD</b>		32. Registrar's Signature 						
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 17 2011</b>								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28202

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Aug. Day 12 Year 2011				3. Time of Death 1500 M	
Julia T. Lemke							
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Anne Arundel Medical Center							
5. Social Security Number 359-07-2258		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 16, 1920	9. Birthplace (State or Foreign Country) IL
Usual Residence of Decedent		10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 800 Bestgate Rd.		10f. Zip Code 21401				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1944-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Bookkeeping		16b. Kind of Business Industry Transportation			
17. Father's Name (First, Middle, Last) George Markunas				18. Mother's Name (First, Middle, Maiden Surname) Magdalena Shimkavitz			
19a. Informant's Name/Relationship (Type, Print) Michael Lemke / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 Charring Ct., Riva, MD 21140					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► <i>[Signature]</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 8/15/2011	20c. Location - City or Town, State Edgewater, MD		
21. Signature of Funeral Service Licensee ► <i>[Signature]</i>		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037					
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of):  <i>hantavirus pneumonia</i></p> <p>b. Due to (or as a consequence of):  <i>chronic obstructive pulmonary disease</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Clostridium difficile colitis</i>							
				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ► <i>[Signature]</i>		29c. License number D16376		29d. Date signed (Month, Day, Year) 8/15/11			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph McFerrin MD, 200 Medical Plaza, Annapolis MD 21401</i>							
31. Date filed (Month, Day, Year) AUG 16 2011		32. Registrar's Signature <i>Anna B. Parks</i>					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28203

1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Salvatore Leto</b>					2. Date of Death Month <b>August</b> Day <b>18</b> Year <b>2011</b>	3. Time of Death <b>7:30 PM</b>									
	4a. Facility Name (if not institution, give street and number) <b>Berlin Nursing Home</b>			4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>										
Funeral Director	5. Social Security Number <b>054-03-7546</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 16, 1915</b>	9. Birthplace (State or Foreign Country) <b>New York</b>									
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Wicomico</b>			10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
To Be Completed by Funeral Director	10e. Street and Number <b>302 Viewfield Drive</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>1941-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>									
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business Industry <b>Food Warehouse</b>										
	17. Father's Name (First, Middle, Last) <b>Andrew Edward Leto, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Maria Modesto</b>												
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Frances Wieland/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>302 Viewfield Drive, Salisbury, MD 21804</b>													
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pine Lawn Mem. Park</b>		Date <b>8/26/2011</b>	20c. Location - City or Town, State <b>Farmingdale, New York</b>										
	21. Signature of Funeral Service Licensee <b>Diane Ceruzzi</b>		22. Name and Address of Facility <b>Keller Funeral Home, P.O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	<table border="1"> <tr> <td>a. Due to (or as a consequence of): <b>Failure to Thrive</b></td> <td>Approximate Interval Between Onset and Death <b>6mo</b></td> </tr> <tr> <td>b. Due to (or as a consequence of): <b>Advance Dementia</b></td> <td><b>1/15</b></td> </tr> <tr> <td>c. Due to (or as a consequence of): <b>Coronary Artery Disease</b></td> <td><b>1/15</b></td> </tr> <tr> <td>d. Due to (or as a consequence of): <b>Hypertension</b></td> <td><b>1/15</b></td> </tr> </table>								a. Due to (or as a consequence of): <b>Failure to Thrive</b>	Approximate Interval Between Onset and Death <b>6mo</b>	b. Due to (or as a consequence of): <b>Advance Dementia</b>	<b>1/15</b>	c. Due to (or as a consequence of): <b>Coronary Artery Disease</b>	<b>1/15</b>	d. Due to (or as a consequence of): <b>Hypertension</b>	<b>1/15</b>
a. Due to (or as a consequence of): <b>Failure to Thrive</b>	Approximate Interval Between Onset and Death <b>6mo</b>															
b. Due to (or as a consequence of): <b>Advance Dementia</b>	<b>1/15</b>															
c. Due to (or as a consequence of): <b>Coronary Artery Disease</b>	<b>1/15</b>															
d. Due to (or as a consequence of): <b>Hypertension</b>	<b>1/15</b>															
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Schizophrenia</b>															
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
	29b. Signature and title of certifier <b>Diane Ceruzzi, D.O.</b>		29c. License number <b>H 0070020</b>			29d. Date signed (Month, Day, Year) <b>August 19, 2011</b>										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Diane Ceruzzi, D.O., 9715 Healthway Dr, Berlin, MD 21811</b>															
	31. Date filed (Month, Day, Year) <b>AUG 28 2011</b>		32. Registrar's Signature <b>Diane Ceruzzi</b>													

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28204

## Certificate of Death

Reg. No.

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

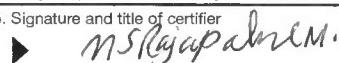
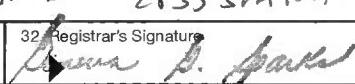
Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>Agnes Lamoreaux</b>		2. Date of Death Month <b>08</b> Day <b>13</b> Year <b>2011</b>		3. Time of Death <b>4:45 PM</b>
4a. Facility Name (if not institution, give street and number) <b>279 Hollingsworth Manor</b>		4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>
5. Social Security Number <b>220-20-9199</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months    Days    Hours    Min.
				8. Date of Birth (Month, Day, Year) <b>05/01/1925</b>
				9. Birthplace (State or Foreign Country) <b>West Virginia</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Cecil</b>	10c. City, Town or Location <b>Elkton</b>	
10e. Street and Number <b>279 Hollingsworth Manor</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Quality Control Inspector</b>		16b. Kind of Business Industry <b>Textile</b>
17. Father's Name (First, Middle, Last) <b>Frank Bozic</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Kolenz</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sandee Hoover/ Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>279 Hollingsworth Manor; Elkton, MD 21921</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Med Cure Inc.</b>		Date <b>08/17/2011</b> Location - City or Town, State <b>Cumberland, RI</b>
21. Signature of Funeral Service Licensee  M01613		22. Name and Address of Facility <b>Gerald N. Minich Funeral Home 305 N. Potomac Street Hagerstown, MD 21740</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <b>End-Stage Parkinsons</b>				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. Describe how injury occurred		
29b. Signature and title of certifier 		29c. License number <b>00057465</b>		29d. Date signed (Month, Day, Year) <b>8/17/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N.S. Rayapati, M.D. 2835 S. Main AV S-203 Baltimore MD 21204</b>				
31. Date filed (Month, Day, Year) <b>AUG 17 2011</b>		32. Registrar's Signature 		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 25,27,28a-f per me, g918,08/31/2011dhp

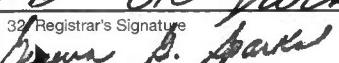
Certificate of Death

Reg. No.

2011 28205

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>ROBERT GEORGE MATTHEWS</b>		2. Date of Death Month <b>AUGUST</b> Day <b>21</b> Year <b>2011</b>	3. Time of Death <b>2:10 P M</b>
4a. Facility Name (if not institution, give street and number) <b>CORSICA HILLS NURSING HOME</b>		4b. City, Town, or Location of Death <b>CENTREVILLE</b>	
4c. County of Death <b>QUEEN ANNE'S</b>		4d. County of Birth <b>QUEEN ANNE'S</b>	
5. Social Security Number <b>579-50-1478</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>73</b> Yrs.
		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
		8. Date of Birth (Month, Day, Year) <b>08/21/1938</b>	
		9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>	
Usual Residence of Decedent			
10a. State <b>MD</b>	10b. County <b>QUEEN ANNE'S</b>	10c. City, Town or Location <b>STEVENSVILLE</b>	
10e. Street and Number <b>812 BUCKINGHAM DRIVE</b>		10f. Zip Code <b>21666</b>	10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>MECHANIC</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM C. MATTHEWS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LAURA L. MORRIS</b>	
19a. Informant's Name/Relationship (Type, Print) <b>CHARLES E. MATTHEWS / BROTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1703 BAYSIDE DRIVE, CHESTER, MD 21619</b>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CENTER</b>	Date <b>08/22/2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>minutes</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
a. Due to (or as a consequence of): <b>Hypoxia and hypercarbia</b>			
b. Due to (or as a consequence of): <b>Aspiration</b>			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Quadriplegia</b>			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>1945 or 1946</b>	28b. Time of Injury <b>Unknown</b>
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Subject fell off rear of car and struck head on fire hydrante</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>34th Street N.W. Washington, DC</b>	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
		29c. License number <b>JCS5953</b>	29d. Date signed (Month, Day, Year) <b>8-22-11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MD Crowley, MD 610 Dutchmans Lane, Easton MD 21601</b>			
31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>		32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28206

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

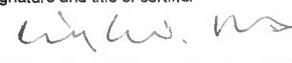
## Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 8 Day 15 Year 2011				3. Time of Death 1:20 PM	
Kathleen Arlee Mathias		Ocean City				Worcester	
4a. Facility Name (if not institution, give street and number) 1523 Teal Dr.		4b. City, Town, or Location of Death Ocean City				4c. County of Death Worcester	
5. Social Security Number 217-62-3178		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 1/17/1953	9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Ocean City							
10e. Street and Number 1523 Teal Dr.		10f. Zip Code 21842				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business Industry City Clerk			Town of Ocean City
17. Father's Name (First, Middle, Last) Edward O. Petry				18. Mother's Name (First, Middle, Maiden Surname) Anita Roberts			
19a. Informant's Name/Relationship (Type, Print) James N. Mathias, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1523 Teal Dr., Ocean City, MD 21842					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		Date 8/19/2011	20c. Location - City or Town, State Berlin, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a.  Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D26278				29d. Date signed (Month, Day, Year) 8-17-11	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID E. CARROLL, MD CASTAL HOSPICE P.O. BOX 1733 SAVANNAH, GA 31402							
31. Date filed (Month, Day, Year) AUG 18 2011		32. Registrar's Signature 					

ORIGINAL

## Certificate of Death

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>James Patton McGhee Jr.</b>						2. Date of Death Month Day Year <b>August 10, 2011</b>	3. Time of Death 0635 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>1093 Crestview Drive</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>		
		5. Social Security Number <b>215-78-1848</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) <b>08/24/1959</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
		Usual Residence of Decedent 10a. State <b>MD</b>						10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number <b>1093 Crestview Drive</b>			10f. Zip Code <b>21409</b>			10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: specify: <b>White</b>	14. Race - American Indian, Black, White, etc.					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>	16b. Kind of Business/Industry <b>Construction</b>						
		17. Father's Name (First, Middle, Last) <b>James P. McGhee, Sr.</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Maryjane Creelman</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Jennifer McGhee / Wife</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1093 Crestview Drive Annapolis, MD 21409</b>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, INC.</b>	Date <b>August 12, 2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>					
		21. Signature of Funeral Service Licensee	22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146</b>							
Physician / Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Asphyxia due to Hanging</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED						Approximate Interval Between Onset and Death		
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year						
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene							
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>FOUND: Aug 10, 2011</b>	28b. Time of Injury <b>FOUND: 0612 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Subject hanged self</b>				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Deck of Residence</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1093 Crestview Drive, Annapolis, MD</b>							
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier 	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 11, 2011</b>						
		30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>								
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>	32. Registrar's Signature 							

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

A/H  
6

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 23a-d, 25, per me, 8919 9-16-11 sm

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28208

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		<b>KATHERINE JONES MAULE</b>		Month AUGUST Day 13, Year 2011		9:05 P M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death		4d. Outside City Limits	
<b>QUEEN ANNE'S COUNTY HOSPICE HOUSE</b>		<b>CENTREVILLE</b>		<b>QUEEN ANNE'S</b>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
5. Social Security Number <b>221-20-0239</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) <b>78</b> Yrs.		If Under 1 Year Months If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>5-7-1933</b>	
9. Birthplace (State or Foreign Country) <b>DELAWARE</b>		10a. State <b>MD</b>		10b. County <b>QUEEN ANNE'S</b>		10c. City, Town or Location <b>MILLINGTON</b>	
10e. Street and Number <b>405 CHESTER RIVER HEIGHTS RD.</b>		10f. Zip Code <b>21651</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business Industry <b>BOOK KEEPER</b>			
17. Father's Name (First, Middle, Last) <b>HARRY C. JONES</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FLORENCE WILLEY</b>					
19a. Informant's Name/Relationship (Type, Print) <b>WILLIAM RUSSELL MAULE, IV</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>405 CHESTER RIVER HEIGHTS RD. MILLINGTON, MD 21651</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CRUMPTON CEMETERY</b>		Date <b>8-19-2011</b>	20c. Location - City or Town, State <b>CRUMPTON, MD</b>
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21. Signature of Funeral Service Licensee <b>Veronica M. Nelligan</b>		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME P.A.</b> <b>130 SPEER RD. CHESTERTOWN, MD 21620</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Sacral Decubitus</b>		23c. Due to (or as a consequence of): <b>Sacral Infection</b>		23d. Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last		23e. Due to (or as a consequence of): <b>Immobility</b>		23f. Due to (or as a consequence of): <b>Complications of Rheumatoid Arthritis</b>			
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23g. 23e. Did tobacco use contribute to the cause of death?			
23g. 23e. Did tobacco use contribute to the cause of death?		23h. 23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23i. 23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23j. 23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
23k. 23i. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23l. 23j. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House QM</b>		23m. 23k. Did the death occur within 24 hours after death?		23n. 23l. Did the death occur within 24 hours after death?	
23o. 23m. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23p. 23n. Did the death occur within 24 hours after death?		23q. 23o. Did the death occur within 24 hours after death?		23r. 23p. Did the death occur within 24 hours after death?	
23s. 23q. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23t. 23r. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House QM</b>		23u. 23s. Did the death occur within 24 hours after death?		23v. 23t. Did the death occur within 24 hours after death?	
23w. 23u. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		23x. 23v. Date of injury (Month, Day, Year)		23y. 23w. Time of injury M		23z. 23x. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23aa. 23y. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		23bb. 23z. Describe how injury occurred		23cc. 23aa. Location (Street and Number or Rural Route Number, City or Town, State)			
23dd. 23cc. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		23ee. 23dd. Signature and title of certifier <b>L. D. Benjamin</b>		23ff. 23ee. License number <b>D16498</b>		23gg. 23ff. Date signed (Month, Day, Year) <b>8/15/11</b>	
23hh. 23gg. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne Benjamin, MD 6602 Church Hill Road Chestertown, MD 21620</b>		23ii. 23hh. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		23jj. 23ii. Registrar's Signature <b>Jane A. [Signature]</b>		23kk. 23jj. Date signed (Month, Day, Year)	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

3  
25  
State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend#3, per Dr., QACHD, ms, 8/18/11 Registrar

## Certificate of Death

Reg. No.

2011 28209

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
<b>EMILY DODD MORRIS</b>	Month AUGUST	Day 16 Year 2011
	2:45 PM	

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
<b>ROCK SPRING VILLAGE ASSISTED LIVING</b>	<b>FOREST HILL</b>	<b>HARFORD</b>

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	8. Date of Birth	9. Birthplace (State or Foreign Country)
<b>217-46-3710</b>	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	95 Yrs.	Month JUNE Day 10 Year 1916	<b>MARYLAND</b>

Usual Residence of Decedent		10d. Inside City Limits
10a. State	10b. County	10c. City, Town or Location
<b>MD</b>	<b>HARFORD</b>	<b>BEL AIR</b>

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
<b>1106 LEESWOOD ROAD</b>	<b>21014</b>	<b>USA</b>

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	Specify: <b>WHITE</b>

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry
Elementary/Secondary (0-12) <b>11</b>	College (1-4 or 5+) <b>-0-</b>	<b>HOME MAKER</b>

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
<b>HENRY DODD</b>	<b>JANIE ELIZABETH DONAHUE</b>

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<b>JANE DRUPIESKI/ DAUGHTER</b>	<b>1106 LEESWOOD ROAD, BEL AIR, MD 21014</b>

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	<b>WOODLAWN MEMORIAL PARK</b>	<b>AUG. 22, 2011</b>	<b>EASTON, MARYLAND</b>

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
<i>Cherry Heggins</i>	<b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617</b>

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <b>CVA</b> Due to (or as a consequence of):  <b>ASVD</b>	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Atrial Fibrillation</b> <b>Diabetes</b> <b>Dementia</b>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted living</b>
---	--	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
---

29b. Signature and title of certifier <i>Cherry Heggins</i>	29c. License number <b>D28469</b>	29d. Date signed (Month, Day, Year) <b>8/16/11</b>
--	--------------------------------------	---

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)
<b>Flora H. Sokal MD 615 W MacPhail Rd Bel Air Md 21014</b>

31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>	32. Registrar's Signature <i>Leanne A. Jones</i>
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ORIGINAL

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28210

1- For State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Kirk Bruce MacKinnon</b>					2. Date of Death Month Day Year <b>August 24, 2011</b>	3. Time of Death 1948 hrs		
	4a. Facility Name (if not institution, give street and number) <b>44322 Ivy Stone Lane</b>					4b. City, Town, or Location of Death <b>California</b>	4c. County of Death <b>St. Mary's</b>		
<b>Funeral Director</b>	5. Social Security Number <b>004-66-7456</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>43</b> Yrs.	If Under 1 Year Months Days Hours Min. 	B. Date of Birth (MM/DD/YYYY) <b>05/07/1968</b>	9. Birthplace (State or Foreign Country) <b>Maine</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b>					10b. County <b>St. Mary's</b>	10c. City, Town or Location <b>California</b>	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>44322 Ivy Stone Lane</b>			10f. Zip Code <b>20619</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Conference Center Manager</b>			16b. Kind of Business/Industry <b>Restaurant Management</b>			
17. Father's Name (First, Middle, Last) <b>Ewen Ian Stewart MacKinnon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Ann Lynch</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Ewen Ian S. MacKinnon/Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>42 Cushing Road, Vassalboro, ME 04989</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>[Signature]</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Charles Memorial Cem</b>		Date <b>08/31/2011</b>	20c. Location - City or Town, State <b>Leonardtown, MD</b>			
21. Signature of Funeral Service Licensed <i>[Signature]</i>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A.</b>					
Edward N. Brinsfield, Jr. M00052				22955 Hollywood Road, Leonardtown, MD 20650					
<b>Physician/ Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line <b>Cardiac arrhythmia associated with myocarditis, dilated cardiomyopathy and focal coronary artery atherosclerosis</b>						Approximate Interval Between Onset and Death		
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g922 12-8-11 sm							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obesity</b>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier <i>Theodore M. King, Jr., MD.</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 25, 2011</b>					
31. Date filed (Month, Day, Year) <b>AUG 29 2011</b>		32. Registrar's Signature <i>Laura J. Parker</i>		ORIGINAL					

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 2821

1 - For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

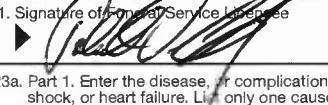
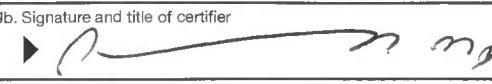
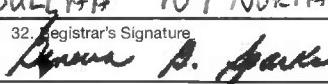
Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

McKnight, Helen  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>HELEN ELIZABETH MCKNIGHT</b>		2. Date of Death Month <b>AUGUST</b> Day <b>10</b> Year <b>2011</b>	3. Time of Death <b>09:27 AM</b>
4a. Facility Name (if not institution, give street and number) <b>410 RAZOR STRAP ROAD</b>		4b. City, Town, or Location of Death <b>NORTH EAST</b>	
4c. County of Death <b>CECIL</b>		4d. Birthplace (State or Foreign Country) <b>HINTON WEST VIRGINIA</b>	
5. Social Security Number <b>236-26-4963</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.
		If Under 1 Year Months	If Under 24 Hrs. Hours
		Days	Min.
		8. Date of Birth (Month, Day, Year) <b>APRIL 1, 1922</b>	
		9. Birthplace (State or Foreign Country) <b>HINTON WEST VIRGINIA</b>	
10a. State <b>MARYLAND</b>		10b. County <b>CECIL</b>	10c. City, Town or Location <b>NORTH EAST</b>
10e. Street and Number <b>410 RAZOR STRAP ROAD</b>		10f. Zip Code <b>21901</b>	10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) WAITRESS</b>	16b. Kind of Business Industry <b>RESTAURANT</b>
17. Father's Name (First, Middle, Last) <b>CLARENCE EVANS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY HAGER</b>	
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT MCKNIGHT / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>120 EAST THOMAS AVENUE, NORTH EAST, MARYLAND 21901</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MARYLAND STATE ANATOMY BOARD</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND STATE ANATOMY BOARD</b>	20c. Date <b>AUGUST 18, 2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Chronic obstructive Pulmonary Disease</b>		Approximate Interval Between Onset and Death <b>710 years</b>	
b. Due to (or as a consequence of): <b>Hyperension</b>		<b>710 years</b>	
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dyslipidemia</b> <b>Osteoporosis</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DOO 64 911</b>	
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>08/17/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MUHAMMAD ABDULLAH 107 NORTH BRIDGE STREET, ELKTON, MARYLAND 21921</b>		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>	
32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

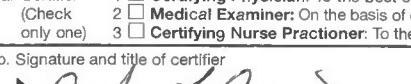
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28212

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GENEVA D. MENTZ</b>				2. Date of Death Month AUGUST Day 15 Year 2011	3. Time of Death 21:46 PM			
	4a. Facility Name (if not institution, give street and number) <b>UNION HOSPITAL OF CECIL COUNTY</b>		4b. City, Town, or Location of Death <b>ELKTON</b>		4c. County of Death <b>CECIL</b>				
Funeral Director	5. Social Security Number <b>235-44-0323</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 9, 1929</b>	9. Birthplace State or Foreign Country <b>SPLITFORK WEST VIRGINIA</b>		
	Usual Residence of Decedent 10a. State <b>MARYLAND</b>		10b. County <b>CECIL</b>		10c. City, Town or Location <b>ELKTON</b>		10d. Inside City Limits XX Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>302 SKIPJACK COURT</b>			10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business Industry <b>OWN HOME</b>				
	17. Father's Name (First, Middle, Last) <b>JOHN WILLIAM UDY</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY ELIZABETH WILLIAMS</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>HUBERT C. MENTZ, JR. / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>592 MOUNTAIN HILL ROAD, PERRYVILLE, MARYLAND 21903</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ELKTON CEMETERY</b>		Date <b>AUGUST 20, 2011</b>	20c. Location - City or Town, State <b>ELKTON, MARYLAND</b>			
	21. Signature of Funeral Service Licensed 		22. Name and Address of Facility <b>CROUCH FUNERAL HOME, P.A.</b> <b>127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901</b>						
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute Myocardial Infarction</b>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Coronary Artery Disease</b>							20 years	
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Atrial Fibrillation</b>							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number <b>D62687</b>			29d. Date signed (Month, Day, Year) <b>August 16, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew L. Aswegan, MD</b>		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>						
			32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. For State Amend Items 24a per verb., g919, 09/01/2011 dnb  
Registrar Certificate of Death

2011 28213  
Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MURIEL E. MINNER</b>						2. Date of Death Month Day Year <b>August 21 2011 0559 AM</b>	3. Time of Death	
	4a. Facility Name (if not institution, give street and number) <b>Memorial Hospital Easton</b>			4b. City, Town, or Location of Death <b>Easton</b>			4c. County of Death <b>Talbot</b>		
Funeral Director	5. Social Security Number <b>219-08-6764</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>05-22-1930</b>	9. Birthplace (State or Foreign Country) <b>TRAINER, PA</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b> 10b. County <b>CAROLINE</b> 10c. City, Town or Location <b>DENTON</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1018 N. HERITAGE COURT</b>			10f. Zip Code <b>21629</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business Industry <b>TEXTILE</b>			
	17. Father's Name (First, Middle, Last) <b>GEORGE B. RASH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELLA LONGFELLOW</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>LARRY MINNER - SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21100 FONDANT AVE NORTH, FOREST LAKE, MN 55025</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MILFORD COMM. CEM.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>8/26/11</b>	20c. Location - City or Town, State <b>MILFORD, DE</b>			
	21. Signature of Funeral Service Licensee <b>George M. Short</b>			22. Name and Address of Facility <b>BERRY-SHORT FUNERAL HOME 119 NW FRONT ST., MILFORD, DE 19963</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>probable atherosclerotic cardiovascular disease</b>						Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyperlipidemia/Atrial Fibrillation /Hypertension</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>J0048137</b>			29d. Date signed (Month, Day, Year) <b>August 23, 2011</b>			
	29b. Signature and title of certifier <b>Michael G. Tooker</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael G. Tooker, MD</b>						31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>		
							32. Registrar's Signature <b>Janice A. Parker</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend 26 per phys., DOR,  
State Registrar 8/19/11, LDB

Certificate of Death

Reg. No. 2011 28214

Physician/ Medical Examiner	Norman Triant Nichols				2. Date of Death Month Day Year Aug. 13, 2011	3. Time of Death 8:41 P.M.
	Coastal Hospice on the Lake		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 214-32-5983	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 13, 1934	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State MD		10b. County Dorchester	10c. City, Town or Location Cambridge	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 708 Governors Ave.		10f. Zip Code 21613		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 11th	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business Industry Retail Merchandise Store	
	17. Father's Name (First, Middle, Last) Roland Nichols		18. Mother's Name (First, Middle, Maiden Surname) Denisea Demery			
	19a. Informant's Name/Relationship (Type, Print) Wendy C. Nichols		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Governors Ave. Cambridge, MD 21613		20c. Location - City or Town, State Cambridge, MD	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mid-Shore Cremation Cemetery Colleen Curren Brownell		Date Aug. 17, 2011	
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee ► Janelle C. Henry		22. Name and Address of Facility Henry Funeral Home P.A. 510 Washington St. Cambridge, MD 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of) End stage emphysema		Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
			c. Due to (or as a consequence of):			
			d. Due to (or as a consequence of):			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier ► Nancy MD		29c. License number D 47924		29d. Date signed (Month, Day, Year) 8-17-2011	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN TITANAWAY 503 BYRN ST CAMBRIDGE MD 21613					
	31. Date filed (Month, Day, Year) AUG 17 2011		32. Registrar's Signature Anna J. Jones			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28215

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

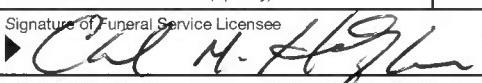
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

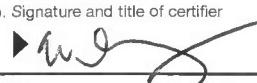
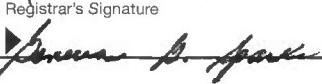
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year			3. Time of Death 2:20 PM
<b>ROBERT R. PRICE, III</b>				AUGUST 18 2011
4a. Facility Name (if not institution, give street and number) <b>325 SAYERS FOREST DRIVE</b>		4b. City, Town, or Location of Death <b>QUEENSTOWN</b>		4c. County of Death <b>QUEEN ANNE'S</b>
5. Social Security Number <b>216-64-8682</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>MARCH 26, 1953</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State <b>MD</b>		10b. County <b>QUEEN ANNE'S</b>		10c. City, Town or Location <b>QUEENSTOWN</b>
10e. Street and Number <b>325 SAYERS FOREST DRIVE</b>			10f. Zip Code <b>21658</b>	
10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4+</b>		16b. Kind of Business Industry <b>LAW</b>
17. Father's Name (First, Middle, Last) <b>ROBERT R. PRICE, JR.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>NANCY BURKE</b>	
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT R. PRICE, JR./FATHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 460, CENTREVILLE, MD 21617</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>12</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESTERFIELD CEMETERY</b>		Date <b>AUG. 23, 2011</b>
21. Signature of Funeral Service Licensee 		20c. Location - City or Town, State <b>CENTREVILLE, MD</b>		
22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617</b>				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>6 years</b>
<p>a. <i>Metastatic Melanoma</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alport Syndrome</b> <b>MAC infection</b> <b>Squamous cell carcinoma of the skin</b>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>MD</b>			29c. License number <b>038409</b>
					29d. Date signed (Month, Day, Year) <b>8/19/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Sharpen 10753 FALLS Rd #415, Centreville, MD, 21617</b>					
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28216

1 For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Felicia Pages</b>						2. Date of Death Month Day Year <b>August 21, 2011</b>		3. Time of Death 2:58 p M		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>St. Mary's Hospital</b>						4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>		
Funeral Director		5. Social Security Number <b>204-24-6120</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>3-7-1931</b>	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>St. Mary's</b> 10c. City, Town or Location <b>Lexington Park</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		10e. Street and Number <b>48385 Lavelle Way</b> 10f. Zip Code <b>20653</b>						10g. Citizen of What Country? <b>U.S.A.</b>				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify <b>Puerto Rican</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Puerto Rican</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>			16b. Kind of Business Industry <b>Own Home</b>				
		17. Father's Name (First, Middle, Last) <b>Eugenio Perez</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Arcadia Ortiz</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Orlando Pages / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29205 North 46th Place, Cave Creek, Arizona 85331</b>							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brinsfield - Echoes</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date <b>08/25/2011</b>	20c. Location - City or Town, State <b>Charlotte Hall, MD</b>			
		21. Signature of Funeral Service Licensee <b>Danielle N. Ward M01403</b>			22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b>						Approximate Interval Between Onset and Death				
		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b> <b>Advanced Dementia</b> <b>Malnutrition</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
		29b. Signature and title of certifier <b>Patricia Gurny, M.D.</b>			29c. License number <b>D26344</b>			29d. Date signed (Month, Day, Year) <b>08/24/2011</b>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia Gurny, M.D.</b>						25500 Hollywood RD., Leonardtown, MD 20650				
		31. Date filed (Month, Day, Year) <b>AUG 26 2011</b>			32. Registrar's Signature <b>Suzanne A. Gurny</b>							

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amended #20b, 8/12/11, RM, Kent State of Maryland / Department of Health and Mental Hygiene

## **1 - State Registrar**

### *Certificate of Death*

Reg. No.

2011 28217

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Corlis Robinson</i>				2. Date of Death Month <i>August</i> Day <i>10</i> Year <i>2011</i>		3. Time of Death <i>11:00 AM</i>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>Northwest Hospital</i>			4b. City, Town, or Location of Death <i>Randalls Town</i>		4c. County of Death <i>Baltimore County</i>			
To Be Completed by Funeral Director		5. Social Security Number <i>216-56-0545</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>60</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>01/20/1951</i>	9. Birthplace (State or Foreign Country) <i>MD</i>	
		Usual Residence of Decedent		10a. State <i>MD</i>		10b. County <i>Kent</i>	10c. City, Town or Location <i>Chestertown</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <i>160 Flatland RD Apt. 119</i>				10f. Zip Code <i>21620</i>		10g. Citizen of What Country? <i>USA</i>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1968</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>		14. Race - American Indian, Black, White, etc.		
		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housekeeping</i>		16b. Kind of Business Industry <i>Washington College</i>				
		17. Father's Name (First, Middle, Last) <i>Medford</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Phillips Josephine</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Walker</i>				
		19a. Informant's Name/Relationship (Type, Print) <i>James Robinson/Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8540 Caulks Field RD Chestertown, MD 21620</i>						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>ST. George UM Church</i>		20b. Place of Disposition (Name of cemetery/crematory or other place) <i>George</i> Date <i>8/17/2011</i>		20c. Location - City or Town, State <i>Worton, MD</i>				
		21. Signature of Funeral Service License <i>James Robinson</i>		22. Name and Address of Facility <i>Bennie Smith Funeral Home 855 High ST Chestertown, MD 21620</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Central pontine myelinolysis</i>		23b. Due to (or as a consequence of): <i>Central pontine myelinolysis</i>		Approximate Interval Between Onset and Death						
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Stroke</i>		23d. Due to (or as a consequence of): <i>Stroke</i>								
23e. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> In-patient hospice								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <i>8/17/2011</i>		28b. Time of injury <i>M</i>	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore MD 21209</i>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>N.S. Rajapakse, M.D.</i>		29c. License number <i>00057465</i>		29d. Date signed (Month, Day, Year) <i>8/11/11</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N.S. Rajapakse, M.D.</i>										
31. Date filed (Month, Day, Year) <i>AUG 12 2011</i>		32. Registrar's Signature <i>S. J. Park</i>								
State Registrar										

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial/transit

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial/transit

5

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 2 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

**Physician  
Medical  
Examiner**

DHMH 17 Rev 7/2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28218

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

\* Funeral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical Examiner

Raven Josephine  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>JOSEPHINE ROWE</b>						2. Date of Death Month      Day      Year <b>AUGUST 14 2011</b>		3. Time of Death 5:05 P M		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>UPPER CHESAPEAKE MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>BEL AIR</b>			4c. County of Death <b>HARFORD</b>				
* Funeral Director		5. Social Security Number <b>115-44-8809</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months      Days      Hours      Min.			8. Date of Birth (Month, Day, Year) <b>MARCH 11, 1926</b>	9. Birthplace (State or Foreign Country) <b>JAMAICA</b>			
To Be Completed by Funeral Director		Usual Residence of Decedent <b>MARYLAND HARFORD</b>		10c. City, Town or Location <b>BELCAMP</b>						10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
To Be Completed by Funeral Director		10e. Street and Number <b>1307 LAVENDER LANE</b>				10f. Zip Code <b>21017</b>		10g. Citizen of What Country? <b>USA</b>				
To Be Completed by Funeral Director		11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSING ASSISTANT</b>			16b. Kind of Business Industry <b>PRIVATE CARE</b>				
To Be Completed by Funeral Director		17. Father's Name (First, Middle, Last) <b>SAMUEL GRANT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES BLAIR</b>						
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) <b>JACQUELINE ROWE (DAUGHTER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1307 LAVENDER LANE, BELCAMP, MARYLAND 21017</b>							
To Be Completed by Funeral Director		20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ATLANTIC CREMATORY</b>			Date <b>08/22/11</b>	20c. Location - City or Town, State <b>GLEN BURNIE, MARYLAND</b>			
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee <b>Lisa Scott-Cohen</b>			22. Name and Address of Facility <b>LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Respiratory failure</b>									Approximate Interval Between Onset and Death	
Physician/ Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Aspiration pneumonia</b>										
Physician/ Medical Examiner		23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>									23d. Date of delivery Month Day Year	
Physician/ Medical Examiner		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>									23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
Physician/ Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke</b>									24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	
Physician/ Medical Examiner		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>									23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
Physician/ Medical Examiner		25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>									26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>	
Physician/ Medical Examiner		27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of injury (Month, Day, Year) <b>1 <input type="checkbox"/> M</b>	28b. Time of injury <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred				
Physician/ Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Physician/ Medical Examiner		29a. Certifier <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>			29c. License number <b>D 63420</b>						29d. Date signed (Month, Day, Year) <b>August 14, 2011</b>	
Physician/ Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sid Z. Khanal - 500 Chesapeake Dr Bel Air MD 21014</b>									31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>	
Physician/ Medical Examiner		32. Registrar's Signature <b>Raven A. Josephine</b>									33. Original	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28219

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Kelli Marie Rowe</b>				2. Date of Death Month <b>August</b> Day <b>12</b> Year <b>2011</b>		3. Time of Death 0635 M					
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Meritus Medical Center</b>				4b. City, Town, or Location of Death <b>Hagers town</b>		4c. County of Death <b>Washington</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>213-86-6430</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Aug. 17, 1966</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
		Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Washington</b>				10c. City, Town or Location <b>Smithsburg</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
		10e. Street and Number <b>13577 Edgemont Rd.</b>				10f. Zip Code <b>21783</b>		10g. Citizen of What Country? <b>U.S.A</b>					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. <b>White</b> Specify:								
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Program Director</b>	16b. Kind of Business Industry <b>Agency</b>								
		17. Father's Name (First, Middle, Last) <b>Dennis P. Deal</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary L. Buscher</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Timothy A. Rowe (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13577 Edgemont Rd. Smithsburg, Md. 21783</b>								
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>Aug 13, 2011</b>	20c. Location - City or Town, State <b>Smithsburg, Md.</b>					
		21. Signature of Funeral Service Licensee <b>J.L. Davis</b> M01414			22. Name and Address of Facility <b>12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783</b>								
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
		<p>a. Due to (or as a consequence of): <b>Pelvic Abscess</b></p> <p>b. Due to (or as a consequence of): <b>Ovarian cancer with metastasis</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier <b>E. Palmer</b>								29c. License number <b>D069946</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eric Palmer, MD 11116 medical campus Rd. Hagerstown, MD 21742</b>								29d. Date signed (Month, Day, Year) <b>8/26/2011</b>			
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>		32. Registrar's Signature <b>S. Palmer</b>									

Baltimore, Maryland 21215-0036

permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Item 25 per me, g918,08/31/2011dhp  
Certificate of Death

Reg. No. 2011 28220

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie K. Shirey</b>						2. Date of Death Month <b>8</b> Day <b>17</b> Year <b>2011</b>	3. Time of Death Hour <b>0521</b> M	
	4a. Facility Name (if not institution, give street and number) <b>Western MD Regional Medical Center</b>			4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>218-50-8122</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Dec 14, 1921</b>	9. Birthplace (State or Foreign Country) <b>Diocet, TX</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b> 10c. City, Town or Location <b>Cumberland</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>828 Bishop Walsh Rd.</b>			10f. Zip Code <b>21502</b>			10g. Citizen of What Country? <b>U.S.A</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>X</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b> <b>Homemaker</b>			16b. Kind of Business Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>David Crockett Kenley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sidney Walters</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Edward Shirey / Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>828 Bishop Walsh Rd. Cumberland, MD 21502</b>					
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rocky Gap Vet Cem</b>			Date <b>8/22/2011</b>	20c. Location - City or Town, State <b>Flintstone, MD</b>	
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Hafer Funeral Service P.A. 1302 National Hwy., LaVale, MD 21502</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cardiac Disease</b>								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): <b>post-operative right knee replacement</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <b>Maryland 00056738</b>			29d. Date signed (Month, Day, Year) <b>8/17/11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Roy Jeffrey Carls, MD</b>			31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>			32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fax to ME  
Division of Vital Records, P.O. Box 68760

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State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 2822

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCIS JEROME SMITHSON</b>							2. Date of Death Month Day Year <b>AUGUST 08, 2011</b>	3. Time of Death 11:30 A M	
	4a. Facility Name (if not institution, give street and number) <b>CHESTER RIVER HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHESTERTOWN</b>			4c. County of Death <b>KENT</b>		
Funeral Director	5. Social Security Number <b>219-18-3837</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>		If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05/02/1925</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>KENT</b>		10c. City, Town or Location <b>CHESTERTOWN</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>101 MORGNEC ROAD APT. 103N</b>				10f. Zip Code <b>21620</b>			10g. Citizen of What Country? <b>UNITED STATES</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>1985</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2</b>		16b. Kind of Business Industry <b>LOGISTICS ANALYST</b>			16c. Kind of Business Industry <b>AIR NATIONAL GAURD</b>		
	17. Father's Name (First, Middle, Last) <b>CHARLES FRANCIS SMITHSON, JR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DOROTHY TYRONE DAVIS</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>JOYCE SMITHSON / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 MORGNEC ROAD APT. 103N CHESTERTOWN, MD 21620</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>CHESAPEAKE CREMATION</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION</b>		Date <b>08/10/2011</b>	20c. Location - City or Town, State <b>STEVENSVILLE, MARYLAND</b>			
	21. Signature of Funeral Service Licensee <i>Kirk J. Helfenstein</i>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>End Stage CHF</i>								Approximate Interval Between Onset and Death <b>2 years</b>	
	b. <i>Atherosclerotic Heart Disease</i> Due to (or as a consequence of): years									
	c. Due to (or as a consequence of): years									
	d. Due to (or as a consequence of): years									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① Chronic Renal Failure ② Hypertension ③ Peripheral arterial Disease ④ CVA</i>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>H. H. Ellman, M.D.</i>				29c. License number <b>D21313</b>				29d. Date signed (Month, Day, Year) <b>8/9/11</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KIN K. WUN, M.D. 415 Washington Ave, Chestertown, MD 21620</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 10 2011</b>		32. Registrar's Signature <i>Anna J. Patel</i>							

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

10  
ms

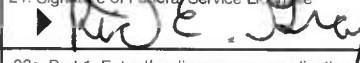
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. N 2011 28222

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last) <b>Jane Rebecca Sherald</b>				2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>2011</b>				3. Time of Death <b>9:50 PM</b>	
4a. Facility Name (if not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>213-24-7529</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 31, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent									
10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>414 Grant Place</b>				10f. Zip Code <b>21702</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>			16b. Kind of Business Industry <b>County Government</b>			
17. Father's Name (First, Middle, Last) <b>J. Thomas Summers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Jane French</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Susan S. Harding, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7995 Mills Manor Court, Thurmont, MD 21788</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>			Date <b>Aug. 29, 2011</b>	20c. Location - City or Town, State <b>Frederick, MD</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Funeral  
Director****To Be Completed by Funeral Director****Medical Certificate: To Be Completed by Physician/Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>Acute Cerebral Vascular Accident</b>				Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of): <b>Acute Stroke</b>							
c. Due to (or as a consequence of): <b>Severe Dementia</b>							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier  <b>Syed W Hague</b>		29c. License number <b>MD0054636</b>		29d. Date signed (Month, Day, Year) <b>8/25/11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Syed W Hague 700 Montclair Ave Frederick, MD 21701</b>							
31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28223

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

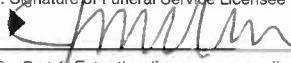
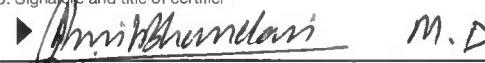
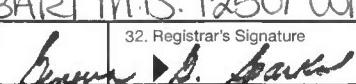
Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death			
		James William Stevens						Month Day Year		Year			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
		WMHS-RMC			Cumberland			Allegany					
Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth			
		220-34-2190		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	73 Yrs.	Months	Days	Hours	Min.	Month Day Year	9. Birthplace (State or Foreign Country)		
		10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits		
		WV		Mineral		Wiley Ford					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
		Rt. 1 Box 14F				26767				USA			
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.			
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				Specify: white			
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry							
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) machinist		CSX							
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
		Henry Dallas Stevens				Catherine Gertrude Norris							
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20a. Method of Disposition							
		Patricia Stevens wife		Rt. 1 Box 14F Wiley Ford WV 26767		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Sunset Memorial Park		Date	20c. Location - City or Town, State		
		4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)								8/25/2011	Cumberland MD		
		21. Signature of Funeral Service Licensee				22. Name and Address of Facility							
						Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
		Immediate Cause (Final disease or condition resulting in death)											
		a. <u>Respiratory failure</u> Due to (or as a consequence of):											
		b. <u>Lung cancer</u> Due to (or as a consequence of):											
		c. _____ Due to (or as a consequence of):											
		d. <u>Chronic obstructive pulmonary disease</u>											
		Approximate Interval Between Onset and Death											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
		<u>Cardiomyopathy</u>											
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier  M.D.				29c. License number				29d. Date signed (Month, Day, Year)			
						D0071867				8/23/2011			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
		AMIT BHANBARI M.D. 12501 WILLOWBROOK RD. CUMBERLAND, MD 21502											
		31. Date filed (Month, Day, Year)		32. Registrar's Signature									
		SEP 01 2011  S. Parker											

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Req. No. 2011 28224

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

to the Hospital or Attending  
within 24 hours after death

12

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28225

1 - For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

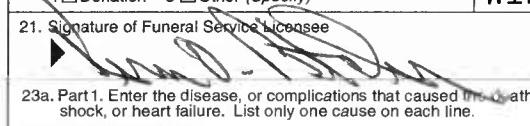
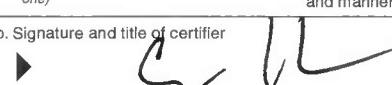
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

## Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last) <b>Harvey Linwood Tracey</b>						2. Date of Death Month Day Year <b>Aug. 24, 2011</b>		3. Time of Death <b>7:30 PM</b>						
		4a. Facility Name (If not institution, give street and number) <b>18429 Middletown Road</b>						4b. City, Town, or Location of Death <b>Parkton</b>		4c. County of Death <b>Baltimore</b>						
		5. Social Security Number <b>215-32-4237</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1928</b>	9. Birthplace (State or Foreign Country) <b>MD</b>						
		Usual Residence of Decedent 10a. State <b>MD</b>						10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkton</b>						
		10e. Street and Number <b>18429 Middletown Road</b>						10f. Zip Code <b>21120</b>		10g. Citizen of What Country? <b>U.S.A.</b>						
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc.					
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Highway Maintenance</b>								
		17. Father's Name (First, Middle, Last) <b>Richard Tracey</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Patterson</b>								
		19a. Informant's Name/Relationship (Type, Print) <b>Rebecca A. Shisler/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53D S. Constitution Ave. New Freedom, PA 17349</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wiseburg Cemetery</b>			Date <b>Aug. 29, 2011</b>	20c. Location - City or Town, State <b>White Hall, MD</b>				
		21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>JJ Hartenstein Mortuary, Inc 24 N. Second St. New Freedom, PA 17349</b>								
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION</b>						Approximate Interval Between Onset and Death <b>1 day</b>								
		Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CARDIAC VALVULAR DISEASE</b>														
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year								
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>At home</b>											
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 						29c. License number <b>D50232</b>			29d. Date signed (Month, Day, Year) <b>8/25/11</b>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CYRUS ITAM 101 MD 913 R. 00060000 RD 570 312 STANIS MO 21152</b>														
		31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>			32. Registrar's Signature 											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28226

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Matthew Alfonza Watson

2. Date of Death  
Month Day Year  
August 5, 20113. Time of Death  
1910 MFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Dr. Bob's Place

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number  
214-61-6650

6. Sex

 M F

7. Age (In yrs. last birthday)

10

Yrs.

If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)  
June 10, 20019. Birthplace (State or Foreign  
Country)  
MD10a. State  
MD

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

 Yes  No10e. Street and Number  
5803 Bost Lane10f. Zip Code  
2073510g. Citizen of What Country?  
United States11. Marital Status  
 Never Married  Married  
 Widowed  Divorced12. Was Decedent Ever in U.S.  
Armed Forces? Yes  No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes  No Specify:14. Race - American Indian,  
Black, White, etc.  
 African  
American  
Specify:15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Seconday (0-12) 0

College (1-4 or 5+)

none

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

16b. Kind of Business Industry

none

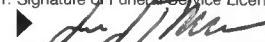
17. Father's Name (First, Middle, Last)  
UNAVAILABLE18. Mother's Name (First, Middle, Maiden Surname)  
Gwen Carolyn Watson19a. Informant's Name/Relationship (Type, Print)  
Gwen Carolyn Watson / Mother19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
5803 Bost Lane, Clinton, MD 2073520a. Method of Disposition  
 Burial  Cremation  Removal from State  
 Donation  Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
National Harmony  
Memorial Park

Date

20c. Location - City or Town, State

08/12/2011

Landover, MD

21. Signature of Funeral Service Licensee  


M00956

22. Name and Address of Facility  
Thibadeau Mortuary Service, p.a.  
7 Park Avenue, Gaithersburg, MD 20877

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

Uremia

Approximate  
Interval Between  
Death and Death

5 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:  
23b. Was decedent pregnant  
in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify)  
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Pancreatitis

Influenza - H1N1

23e. Did tobacco use contribute to the cause of death?

 Yes  No  Probably  Unknown23f. Was an autopsy performed?  
 Yes  No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
 Yes  No25. Was case referred to medical  
examiner?  
 Yes  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify)

hosptice

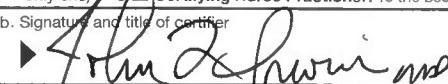
26. Place of Death (Check only one)

27. Manner of Death  
 Natural  Pending  
 Accident  Investigation  
 Suicide  Could not be  
 Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

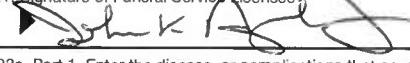
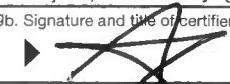
28c. Injury at  
work?1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)  
 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier  
29c. License number  
05621129d. Date signed (Month, Day, Year)  
8/11/1130. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
John F. Irwin, MD 3001 S Hanover St. Baltimore, MD 2122531. Date filed (Month, Day, Year)  
AUG 15 201132. Registrar's Signature  
Linda S. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 27 per dr., g919, 09/06/2011 dhp State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011 28227

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAY THOMAS WOLFENDEN</b>						2. Date of Death Month 8 Day 17 Year 2011	3. Time of Death 0302 M	
	4a. Facility Name (if not institution, give street and number) <b>CARROLL HOSPITAL CENTER</b>			4b. City, Town, or Location of Death <b>WESTMINSTER</b>			4c. County of Death <b>CARROLL CO.</b>		
Funeral Director	5. Social Security Number <b>220-68-3315</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>56 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>01/12/1955</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminster</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>113 Bertie Avenue</b>			10f. Zip Code <b>21157</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Clerk</b>	16b. Kind of Business Industry <b>Shoppers Fish Dept.</b>						
	17. Father's Name (First, Middle, Last) <b>John Thomas Wolfenden</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley Leach</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Robin Wolfenden/sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Bertie Avenue, Westminster, MD 21157</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Final Journey</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Final Journey</b>	Date <b>08/20/2011</b>	20c. Location - City or Town, State <b>Woodbine, MD</b>				
	21. Signature of Funeral Service licensee 		22. Name and Address of Facility <b>Pritts Funeral Home &amp; Chapel 412 Washington Road, Westminster, MD 21157</b>						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Coronary Artery Disease</b>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Hypertension</b>								
	b. Due to (or as a consequence of): <b>Diabetes Mellitus</b>								
	c. Due to (or as a consequence of): <b>Obesity</b>								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number <b>H0070332</b>			29d. Date signed (Month, Day, Year) <b>8/17/11</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JUSTIN GREENE, D.O. CARROLL HOSPITAL CENTER, WESTMINSTER MD</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2011</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, age 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28228

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Bonnie Jean Willard</b>				2. Date of Death Month <b>August</b> Day <b>25</b> , Year <b>2011</b>	3. Time of Death <b>12:15 P.M.</b>		
	4a. Facility Name (if not institution, give street and number) <b>14343 Stottlemeyer Rd.</b>		4b. City, Town, or Location of Death <b>Smithsburg</b>		4c. County of Death <b>Frederick</b>			
<b>Funeral Director</b>	5. Social Security Number <b>214-28-5734</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug. 8, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Smithsburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>14343 Stottlemeyer Road</b>			10f. Zip Code <b>21783</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Food Service</b>		16b. Kind of Business Industry <b>Public Schools</b>			
	17. Father's Name (First, Middle, Last) <b>James Harne</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Wolfe</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Lee Willard (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14343 Stottlemeyer Rd. Smithsburg, Maryland 21783</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garfield United Methodist Church Cem</b>		Date <b>August 29, 2011</b>	20c. Location - City or Town, State <b>Garfield, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783</b>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>C. Chronic Obstructive Disease</b>							
Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. If female: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month <b>0</b> Day <b>0</b> Year <b>0</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>								
				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>D38471</b>		29d. Date signed (Month, Day, Year) <b>8/26/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. William Kerns 22911 Jefferson Blvd. Smithsburg, MD 21783</b>								
31. Date filed (Month, Day, Year) <b>SEP 01 2011</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner****State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28229

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Patricia Andrews</b>						2. Date of Death Month <b>09</b> Day <b>04</b> Year <b>2011</b>	3. Time of Death <b>10:10 PM</b>	
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
<b>Funeral Director</b>	5. Social Security Number <b>216-42-6701</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>Mar 12 1944</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Rosedale</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
10e. Street and Number <b>12 Parham Circle Apartment TB</b>				10f. Zip Code <b>21237</b>				10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bakery Manager</b>			16b. Kind of Business/Industry <b>Grocery</b>			
17. Father's Name (First, Middle, Last) <b>Berle Alvey</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Giaraffa</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Melissa Ciesla - Granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Riverthorn Road, Middle River MD 21220</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>			Date <b>09-06-2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Patricia M. Fleming</b>				22. Name and Address of Facility <b>Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228</b>					
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ovarian Cancer</b>								Approximate Interval Between Onset and Death
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ovarian Cancer</b>								Approximate Interval Between Onset and Death
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>M.D.</b>		29c. License number <b>D0071287</b>				29d. Date signed (Month, Day, Year) <b>9-5-11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>									
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Suzanne S. Parker</b>							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28230

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Julia Evelyn Acker</b>						2. Date of Death Month <b>09</b> Day <b>05</b> Year <b>2011</b>		3. Time of Death <b>3:15 AM</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Renaissance Gardens</b>			4b. City, Town, or Location of Death <b>Catonsville</b>			4c. County of Death <b>Baltimore</b>				
To Be Completed by Funeral Director		5. Social Security Number <b>350125955</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month <b>11</b> Day <b>14</b> Year <b>1920</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>			
To Be Completed by Physician/Medical Examiner		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>709 Maiden Choice Lane #233</b>			10f. Zip Code <b>21228</b>			10g. Citizen of What Country? <b>United States</b>				
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>1920</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>WHITE</b>			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>4 years</b>		Management			16b. Kind of Business Industry <b>Banking</b>			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Edward Ashley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cornelia Tracy</b>						
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>James Acker - SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5901 Deborah Jean Drive, Elkridge MD 21075</b>							
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory INC</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>			Date <b>09-06-2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Patricia M. Fleming</b>			22. Name and Address of Facility <b>Cremation Society Of Maryland</b> <b>299 Frederick Road, Baltimore MD 21228 INC</b>							
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Urinary tract infection</b>						Approximate Interval Between Inset and Death <b>days</b>				
To Be Completed by Physician/Medical Examiner		23b. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9 Unknown</b>						23d. Date of delivery Month Day Year				
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospital</b>								
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <b>Myra Carpenter MD</b>			29c. License number <b>D 30989</b>	29d. Date signed (Month, Day, Year) <b>September 5 2011</b>
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Myra Carpenter MD 711 Maiden Choice Ln Catonsville MD 21228</b>						31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature <b>Leanne N. Parker</b>	

Julia ACKER

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28231

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bobby Anderson</b>				2. Date of Death Month Day Year August 19 2011	3. Time of Death 8:25 A M			
	4a. Facility Name (If not institution, give street and number) <b>6900 Mornington Rd #C</b>		4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>527-18-7931</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>83</b>	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 28, 1928</b>	9. Birthplace (State or Foreign Country) <b>unk</b>			
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>					
	10e. Street and Number <b>6900 Mornington Road 3C</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 groundskeeper</b>		16b. Kind of Business/Industry <b>museum</b>				
	17. Father's Name (First, Middle, Last) <b>unk</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Gertrud Andeson/spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6900 Morington Road #C Dundalk, MD 21222</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CHRONIC KIDNEY DISEASE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIABETES</b> <b>Anemia</b>						Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	3. Ectopic pregnancy <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>CHRONIC LYMPHOID LEUKEMIA</b> <b>HYPERTENSION</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Ronald S. Wade</b>		29c. License number <b>038635-SA</b>		29d. Date signed (Month, Day, Year) <b>8/24/11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9600 NORTH PT. RD. BLDG. HOWARD, MD 21052</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Ronald S. Wade</b>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #17 Per FH G919 9/07/2011 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28232

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 6:50P M
Raymond Brown		9/1/2011		
4a. Facility Name (if not institution, give street and number) <b>Futurecare- Homewood</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
5. Social Security Number <b>216-20-5218</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/13/1927</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>2531 Cecil Avenue</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Department Sanitation</b>		16b. Kind of Business Industry <b>Baltimore City</b>	
17. Father's Name (First, Middle, Last) <b>Isaiah Brown Brown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Jenkins</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Daughter Gertrude Brown</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>447 E. 28th Street Balto MD 21218</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mount CarmelCem</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date <b>9-10-2011</b>	20c. Location - City or Town, State <b>Dundalk MD</b>
21. Signature of Funeral Service Licensee <b>Philip A Weatherford</b>		22. Name and Address of Facility <b>Phillip A Weatherford FSPA 2431 E Oliver St Balto MD 21213</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>cardiovascular accident</i> Due to (or as a consequence of): <i>Hypertension</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>D. Salvi</i>		
		29c. License number <b>D 17537</b>	29d. Date signed (Month, Day, Year) <b>9-6-11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DARSHAN S. SALVAN MD, 6821 Reisterstown Rd, Baltimore MD 21215</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>James B. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28233

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tony Bullock</b>							2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2011</b>	3. Time of Death <b>6:53 PM</b>	
	4a. Facility Name (if not institution, give street and number) <b>Bon Secours Hospital - Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>213-76-0622</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>01-29-59</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
	10a. State <b>MD</b>		10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>601 N. Dukeland Street</b>			10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>African American</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) NA</b>		16b. Kind of Business Industry <b>Laborer</b>			16c. Kind of Business Industry <b>Construction Co.</b>		
	17. Father's Name (First, Middle, Last) <b>Clarence R. Bullock</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Benson</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Marie Bullock-Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>742 W. Lexington Street Baltimore, MD 21201</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>King Mem. Pk.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>09-07-11</b>	20c. Location - City or Town, State <b>Randallstown, MD</b>			
	21. Signature of Funeral Service Licensee <b>Shanele Thompson</b>			22. Name and Address of Facility <b>Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217</b>						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. anoxic encephalopathy</b> Due to (or as a consequence of): <b>b. hemorrhagic shock</b> Due to (or as a consequence of): <b>c. upper GI bleed (acute-on-chronic)</b> Due to (or as a consequence of): <b>d. chronic alcohol abuse</b>								Approximate Interval Between Onset and Death <b>4 days</b> <b>5 days</b> <b>3 weeks</b> <b>4 decades</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Division of Vital Records, P.O. Box 68760 Baltimore, Maryland 21215-0036	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D66108</b>							
	29b. Signature and title of certifier <b>Dell Simmons, M.D.</b>		29d. Date signed (Month, Day, Year) <b>8/30/2011</b>							
	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Leanne J. Parker</b>							

Fifteen to Ninety-Five

Division of Vital Records, P.O. Box 68760  
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28234

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn Sue Bundrick

2. Date of Death

Month Sept. Day 02, Year 2011

3. Time of Death

05:30 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

219-36-1421

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 08, 1940

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

116 Brannan Rd

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business Industry

Textile Manufacturing

17. Father's Name (First, Middle, Last)

Richard Cogswell

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle E. Johnson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Brenda Harron (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Brannan Rd. Aberdeen, Maryland 21001

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

September 06, 2011

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Jeffrey R. Testerman (MD1543)

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services - Bel Air  
3 Newport Drive Forest Hill, Maryland 21050Physician/  
Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

&lt;24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Septic Shock

b. Due to (or as a consequence of):

Multi organ Failure

c. Due to (or as a consequence of):

Hyperkalemia

d. Due to (or as a consequence of):

Lactic acidosis

&lt;24 hrs

&lt;24 hrs

&lt;24 hrs

&lt;24 hrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S septic liver

Coagulopathy

Worsening to peritonitis

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DCA Other:4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey A. Thompson MD

29c. License number

D0053568

29d. Date signed (Month, Day, Year)

September 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey A. Thompson MD

500 Upper Chesapeake Drive

Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

James J. Jackson

State  
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28235

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

BAIL EY ROSA  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <i>Rose Pearl Bailey</i>				2. Date of Death Month <b>09</b> Day <b>01</b> Year <b>2011</b>		3. Time of Death 10:20 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <i>Good Samaritan Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director		5. Social Security Number <b>219-22-0879</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth <b>9-28-1928</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
To Be Completed by Funeral Director		10a. State <b>MD</b> 10b. County				10c. City, Town or Location <i>Baltimore</i>			
		10e. Street and Number <i>1601 E. Belvedere Avenue</i>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Associate</b>			16b. Kind of Business Industry <b>Department Store</b>	
		17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Mae Kelly</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Bernice E. Pumphrey (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Wesley Ave, Baltimore, MD 21228</b>			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of Cemetery, crematory or other place) <b>Woodlawn</b>		Date <b>9-9-11</b>	20c. Location - City or Town, State <b>Woodlawn, MD</b>	
		21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>				22. Name of business facility <b>Vaughn C. Greene funeral Services</b> <b>531 Balt. Nat'l Pike (21229)</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>URS EPSIS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			
		23d. Date of delivery Month <b>0</b> Day <b>0</b> Year <b>0</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		24. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>J72483</b>			
		29b. Signature and title of certifier <b>N Tahir</b>				29d. Date signed (Month, Day, Year) <b>09-01-2011</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NASA TAJIR 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239</b>				31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			
		32. Registrar's Signature <i>Leanne D. Parker</i>							

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2011 28236

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Gwendolyn Barnes</b>						2. Date of Death Month Day Year <b>August 29 2011</b>		3. Time of Death <b>0241 A M</b>			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>			4b. City, Town, or Location of Death <b>Randallstown</b>			4c. County of Death <b>Baltimore</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>212-78-2765</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) <b>50 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct. 31, 1960</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
		Usual Residence of Decedent <b>MD N/A</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
		10e. Street and Number <b>2200 East Biddle St. Apt. 310</b>			10f. Zip Code <b>21213</b>			10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1960</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Disabled</b>			16b. Kind of Business/Industry <b>N/A</b>					
		17. Father's Name (First, Middle, Last) <b>James Miller</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Nixon</b>								
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Angela Starks- Niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9314 Edway Circle Randallstown, MD 21133</b>								
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>King Mem. Park</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Park</b>			Date <b>9-3-11</b>	20c. Location - City or Town, State <b>Randallstown, MD</b>				
		21. Signature of Funeral Service Licensee <b>Sony J. March</b>			22. Name and Address of Facility <b>Gary P. March FH 270 Fredhillton Ross Brpto. MD 20629</b>								
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>						Approximate Interval Between Onset and Death					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			{ a. Due to (or as a consequence of): <b>Hypertension</b> b. Due to (or as a consequence of): <b>End stage renal Disease</b> c. Due to (or as a consequence of): <b>Congestive Heart failure</b> d. Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier <b>Dr. Laura Harlan</b>		29c. License number <b>10051339</b>			29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Laura Harlan 5401 Old Rd. Randallstown MD 21133</b>											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>										32. Registrar's Signature <b>Laura J. Harlan</b>	

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State  
egistrar**

## Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

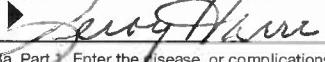
## Certificate of Death

Reg. No.

2011 28237

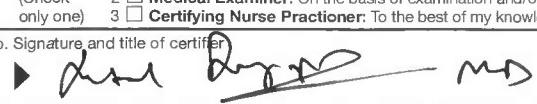
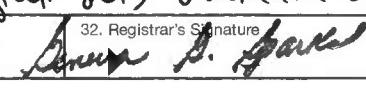
1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Frank Boyd</b>				2. Date of Death Month <b>Aug. 27,</b> Day <b>2011</b> Year				3. Time of Death <b>9:15 PM</b>	
4a. Facility Name (if not institution, give street and number) <b>Manor Care Roland Park</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
5. Social Security Number <b>212-78-5563</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) <b>Apr. 30, 1959</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4916 Nelson Avenue</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>9th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Man</b>				16b. Kind of Business Industry <b>Towyla College</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Boyd</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Mae Holloway</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Larry Lewis/Stepfather</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4910 Queensberry Avenue Baltimore, Maryland</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>				Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Lansdowne, MD</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Chatman-Harris Funeral</b> <b>5240 Reisterstown Rd Baltimore, MD 21215</b>					

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		As w D		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last		{			
a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cirrhosis of liver</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0069314</b>			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>09/02/11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mittal Prajapati 8813 Waltham Woods Rd Parkville MD 21234</b>					
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28238

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby Boy Barnt</b>						2. Date of Death Month <b>08</b> Day <b>19</b> Year <b>2011</b>	3. Time of Death <b>20:55 M</b>		
	4a. Facility Name (If not institution, give street and number) <b>SMHC</b>			4b. City, Town, or Location of Death <b>Clinton</b>			4c. County of Death <b>Prince Georges</b>			
Funeral Director	5. Social Security Number <b>infant</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	If Under 1 Year <b>4</b>	If Under 24 Hrs. <b>2</b>	8. Date of Birth (Month, Day, Year) <b>8-19-11</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	10a. State <b>MD</b>			10b. County <b>Prince George's</b>			10c. City, Town or Location <b>Camp Springs</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>4351 Telfair Blvd</b>			10f. Zip Code <b>20746</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>asian</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>infant</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>infant</b>	16b. Kind of Business/Industry <b>infant</b>							
	17. Father's Name (First, Middle, Last) <b>Anthony Barnt</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Chu Ahng</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Southern Maryland Hospital</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7503 Surratts Road Clinton, MD 20735</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>			22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Frequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. <b>20 week extreme prematurity</b> Due to (or as a consequence of): <b>Pre viable Fetus</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>None</b>									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 			29c. License number <b>D 0063068</b>			29d. Date signed (Month, Day, Year) <b>08/20/2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patrick Jean-Philippe, MD 7503 Surratts Rd, Clinton MD 20735</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 							

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28239

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susan Lynn Burgess</b>					2. Date of Death Month Day Year <b>July 30, 2011</b>	3. Time of Death 4:55 AM M		
	4a. Facility Name (If not institution, give street and number) <b>1 S. Main Street #4</b>			4b. City, Town, or Location of Death <b>Union Bridge</b>		4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>218-64-8301</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 27, 1953</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b>			10c. City, Town or Location <b>Union Bridge</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1 S. Main Street #4</b>			10f. Zip Code <b>21791</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cashier</b>		16b. Kind of Business/Industry <b>un</b>				
	17. Father's Name (First, Middle, Last) <b>Robert Charles Petersen Sr</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Louise Brodander</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Sherry Hose/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41 E. Antietam St Apt 1 Rear, Hagerstown, MD 21740</b>					
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>						
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>lung CA</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Flavio Kruter MD</i>		29c. License number <b>D35398</b>		29d. Date signed (Month, Day, Year) <b>8-18-11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Flavio Kruter 55 S. Center St. Westminster, Md.</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>Suzanne J. Parker</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28240

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 08 Day 21 Year 2011		3. Time of Death 1838 PM
BETTY JO BROMLEY				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
HOLY CROSS HOSPITAL				
5. Social Security Number 518-52-1179		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) 11/11/1937
Usual Residence of Decedent		10a. State MD		10b. County MONTGOMERY
		10c. City, Town or Location SILVER SPRING		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 8505 SPRINGVALE RD		10f. Zip Code 20910		10g. Citizen of What Country? USA
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. unk		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) unk		16b. Kind of Business Industry unk
17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) unk		
19a. Informant's Name/Relationship (Type, Print) HOLY CROSS HOSPITAL		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 FOREST GLEN RD S.S. MD 20910		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		20c. Location - City or Town, State
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>b. PULMONARY EFFUSION Due to (or as a consequence of):</p> <p>c. COLON CANCER Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DB7589		
29b. Signature and title of certifier HAROLD V. LAWSON		29d. Date signed (Month, Day, Year) 08/23/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR HAROLD V. LAWSON, 1500 FOREST GLEN RD. S.S. MD 20910				
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Suzanne S. Parker		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28241

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death 12:58 PM	
Nicole Bibeau		August 22, 2011				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death	
Union Hopsital		Elkton			Cecil	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 7, 1938	9. Birthplace (State or Foreign Country) unk
000-01-3502						
Usual Residence of Decedent						
10a. State MD	10b. County Cecil	10c. City, Town or Location Elkton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3007 Spanish Bay Court		10f. Zip Code 21921			10g. Citizen of What Country? USA	
11. Marital Status unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white		
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		
16b. Kind of Business Industry unk						
17. Father's Name (First, Middle, Last)		unk		18. Mother's Name (First, Middle, Maiden Surname) unk		
19a. Informant's Name/Relationship (Type, Print) Union Hospital		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Bow Street Elkton, MD 21921				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 45 minutes				
a. <i>Cardiac arrest</i> Due to (or as a consequence of):						
b. <i>Respiratory arrest</i> Due to (or as a consequence of):		1 hour				
c. <i>Severe COPD</i> Due to (or as a consequence of):		6 months				
d. _____						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0069854				
29b. Signature and title of certifier Erin M. Reardon MD		29d. Date signed (Month, Day, Year) 8/22/2011				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erin M. Reardon MD, 106 Bow St, Elkton, MD 21921						
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Erin J. Park		33. Original		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28242

Reg. No.

1-  
For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
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Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August Day 25, 2011 Year		3. Time of Death 8:45 PM M
<b>Ruben Benitez</b>		4b. City, Town, or Location of Death <b>Derwood</b>		4c. County of Death <b>Montgomery</b>
4a. Facility Name (if not institution, give street and number) <b>Casey Hospice</b>		4b. City, Town, or Location of Death <b>Derwood</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>unk</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days Hours Min.
8. Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Takoma Park</b>
10e. Street and Number <b>8104 Lockney Avenue</b>		10f. Zip Code <b>20912</b>		10g. Citizen of What Country? <b>Honduras</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Honduras</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>unk</b>		16b. Kind of Business Industry <b>unk</b>
17. Father's Name (First, Middle, Last) <b>Casey Hospice</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>		<b>unk</b>
19a. Informant's Name/Relationship (Type, Print) <b>Casey Hospice</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6001 Muncaster Mill Road Rockville, MD 20855</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		
23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <b>Acquired immune deficiency syndrome</b> Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospice</b>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Bindu Joseph</b>		
		29c. License number <b>D0060634</b>		29d. Date signed (Month, Day, Year) <b>Aug 26, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bindu Joseph 6001 Muncaster Mill Road Rockville, MD 20855</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Senya S. Parker</b>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28243

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Jeffrey Brown</i>		August 25 2011		19:18 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>The Johns Hopkins Hospital</i>		<i>Baltimore City</i>		<i>N/A</i>
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 6/18/1957
217-66-7080				9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore		
		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>1000 Abbott Ct.</i>			10f. Zip Code <i>21202</i>	
			10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>11th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>	16b. Kind of Business Industry <i>Various Jobs</i>	
17. Father's Name (First, Middle, Last) <i>Norman Winegan</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Ruby Brown</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Ruby Brown - Mother</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>601 Wyanoke Ave. Baltimore, MD 21218</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>	Date <i>9/2/2011</i>	20c. Location - City or Town, State <i>Lansdown, MD</i>
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>March F/H 1101 E. North Ave. Baltimore, MD 21202</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Intracerebral Hemorrhage</i>				
Approximate Interval Between Onset and Death				
b. <i>Meningitis</i> Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>[Signature]</i>				
29c. License number <i>RES 000</i>				
29d. Date signed (Month, Day, Year) <i>August 25 2011</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>AJL Kalenius 600 North Wolfe Street Baltimore MD 21287</i>				
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Sheron S. Paul</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28244

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
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once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death 2:30 P M	
Marvin G. Boyer			8-30-2011				
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
Villa Rosa Nursing Home			Mitchellville			Prince Georges	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 19, 1919	9. Birthplace (State or Foreign Country) Pennsylvania
167-12-2641							
Usual Residence of Decedent		10a. State Maryland			10b. County N/A		
		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6606 Danville Avenue			10f. Zip Code 21224			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1 year		16b. Kind of Business Industry Machinist			Lockede Martins
17. Father's Name (First, Middle, Last) George Boyer				18. Mother's Name (First, Middle, Maiden Surname) Annie Hughes			
19a. Informant's Name/Relationship (Type, Print) Michelle Stein Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7815 Sasscer Lane, Upper Marlboro, Maryland 20772				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery			Date September 6, 2011	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee Anthony Connelly			22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222				

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: #1 Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier ► [Signature]						29c. License number D32261		29d. Date signed (Month, Day, Year) 08/31/2011								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard J. Feldman, MD. 8116 Good Luck Road Ste 300, Lanham, MD. 20706																
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature [Signature]														

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 24a per verb., g919 09/07/2011b Certificate of Death

Reg. No. 2011 28245

S.40A4  
8/20/11  
**Baker, Donald E.**

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Donald E. Baker</b>					2. Date of Death Month August Day 20, 2011 Year	3. Time of Death 8:40 a M	
	4a. Facility Name (If not institution, give street and number) <b>Morningside House</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
<b>Funeral Director</b>	5. Social Security Number <b>213-09-0151</b>	6. Sex <b>1 XM 2 F</b>	7. Age (In yrs. last birthday) <b>94 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>June 25, 1917</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>	
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Baltimore County</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number <b>1409 Mt. Airy Rd.</b>			10f. Zip Code <b>21237</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Draftsman</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>			
	17. Father's Name (First, Middle, Last) <b>Emil Baker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mazie Ebersole</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Virginia A. Baker (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1409 Mt. Airy Rd. Baltimore, Md. 21237</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Burial</b>			20b. Place of Disposition (Name of cemetery, crematory or otherplace) <b>Moreland Memorial Cem.</b>		Date <b>8-24-2011</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>	
	21. Signature of Funeral Service Licensee <b>Debbie Johnson</b>			22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>				
	<b>Physician /Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CHF</b>						
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>COPD</b>							
	23c. Due to (or as a consequence of): <b>HTN</b>							
	23d. Due to (or as a consequence of): <b>Atrial fibrillation</b>							
	23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
23f. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) <b>Unknown</b>							23g. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyperparathyroidism</b>							23h. 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>8-23-2011</b>		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4930 Campbell Blvd, Baltimore, MD 21236</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Mohammed N. Faruq, MD</b>		29c. License number <b>DS7061</b>			29d. Date signed (Month, Day, Year) <b>8/23/11</b>			
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Sherman P. Faruq</b>						

#24 of 2011  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

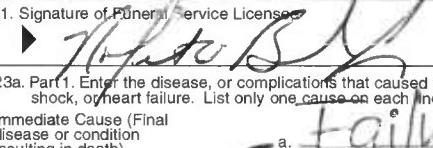
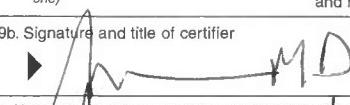
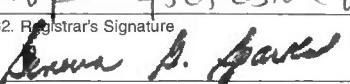
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28246

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Dorothy Franey Casey</b>					2. Date of Death Month Day Year <b>September 4, 2011</b>	3. Time of Death 3:30 A.M.	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Health Services-Ruxton</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
<b>Funeral Director</b>	5. Social Security Number <b>215-09-7828</b>	6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b> </b>	If Under 24 Hrs. Hours Min. <b> </b>	8. Date of Birth (Month, Day, Year) <b>March 22, 1920</b>	9. Birthplace (State or Foreign Country) <b>Balt., Maryland</b>	
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Timonium</b>							
	10e. Street and Number <b>137 E. Timonium Road</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States of America</b>	
	11. Marital Status <b>1 □ Never Married 2 □ Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No Specify: white</b>		14. Race - American Indian, Black, White, etc. <b>Specify: white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Homemaker</b>		16b. Kind of Business/Industry <b>Residence</b>			
	17. Father's Name (First, Middle, Last) <b>Edward Franey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Miller</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Jeffrey B. Casey/ son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4541 Northwoods Trail Hampstead, Maryland 21074</b>			
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, cemetery or other place) <b>Dulaney Valley Memorial Gardens</b>		Date <b>September 7, 2011</b>	20c. Location - City or Town, State <b>Timonium, Maryland</b>		
	21. Signature of Funeral Service Licensee 							
	22. Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093</b>							
<b>Physician /Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. <i>Failure to thrive</i> Due to (or as a consequence of):</p> <p>b. <i>Advanced dementia</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown</b>				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 <input checked="" type="checkbox"/> Unknown</b>								
24a. Was an autopsy performed? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b>						
25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>						
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 □ Accident 3 □ Suicide 4 □ Homicide</b>		28a. Date of Injury (Month, Day, Year) <b> </b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 □ Yes 2 □ No</b>		
5 □ Pending investigation 6 □ Could not be determined		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b> </b>				
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b> </b>								
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
29b. Signature and title of certifier 				29c. License number <b>53593</b>		29d. Date signed (Month, Day, Year) <b>9/5/11</b>		
30. Name and address of person who completed cause of death (Item 23a). (Type, Print) <b>Ashraf Saleh 911 7501 Osia Drive Suite 108 Towson MD 21204</b>								
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28247

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jay Dowling Cherry</b>					2. Date of Death Month <b>August</b>	Day <b>25</b>	Year <b>2011</b>	3. Time of Death <b>8:03 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>30 Dunvale Rd; Apt C</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>297-16-5151</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months <b>89</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug 18, 1922</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>			
To Be Completed by Funeral Director	10a. State <b>MD</b>					10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <b>1 Yes 2 No X</b>
	10e. Street and Number <b>30 C Dunvale Road</b>			10f. Zip Code <b>21204</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4or 5+) 5+</b>		16b. Kind of Business/Industry <b>professor speech pathology</b>					
	17. Father's Name (First, Middle, Last) <b>James Dowling Cherry Sr</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Kuntz</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Warren Cherry/son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 42221 Baltimore, MD 21284</b>				
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Ronald S. Ware, Director</b>					22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
	23a. Part I. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Valvular Heart Disease, AS</b> Due to (or as a consequence of): <b>3 yr</b>									
	b. <b> </b> Due to (or as a consequence of):									
	c. <b> </b> Due to (or as a consequence of):									
	d. <b> </b>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown</b>			23d. Date of delivery Month <b> </b>			Year <b> </b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Coronary Artery Disease Peripheral Vascular Disease. Hyperlipidemia</b>									
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b>			Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>				
	27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day, Year) <b> </b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>Phillip F. MAC, MD, 1442 York Rd, Suite 100, Lutherville, MD 21093</b>							
	29c. License number <b>D53902</b>		29d. Date signed (Month, Day, Year) <b>8/29/14</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Suzanne D. Parker</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28248  
Reg. No.

1 - For  
State  
Register

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Marceline Cain</i>						2. Date of Death Month <input type="text"/> September Day <input type="text"/> 1 Year <input type="text"/> 2011		3. Time of Death <input type="text"/> 10:45 A M		
	4a. Facility Name (if not institution, give street and number) <b>1321 Gold Meadow Way Apt. 102</b>			4b. City, Town, or Location of Death <b>Edgewood</b>			4c. County of Death <b>Harford</b>				
Funeral Director	5. Social Security Number <b>219-58-1087</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) <b>Dec 02, 1949</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	10a. State <input type="text"/> MD 10b. County <input type="text"/> Harford 10c. City, Town or Location <input type="text"/> Edgewood						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>1321 Gold Meadow Way Apt. 102</b>			10f. Zip Code <b>21040</b>			10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <input type="text"/>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <input type="text"/>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>					
	17. Father's Name (First, Middle, Last) <b>Wilmer Chapman</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Viola Hill</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Toyresa Ringgold /Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1410 Perrywood Drive Apt. 203 Aberdeen, MD 21001</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Chesapeake Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date <b>Sep 09, 2011</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Linda Sue Ritter Mo1443</b>			22. Name and Address of Facility <b>Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286</b>							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>End-Stage COPD</b>									Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier <b>N.S.Rajapakse M.D.</b>									29c. License number <b>00057465</b>	29d. Date signed (Month, Day, Year) <b>9/2/11</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N.S.Rajapakse M.D. 2835 Smith Av S 203 Baltimore MD 21209</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature <b>J. Parker</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760

Within 24 hours after death,  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28249

For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emma May Carr</b>						2. Date of Death Month Day Year <b>August 30, 2011</b>	3. Time of Death 5:00 A.M.	
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice @ GBMC</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-20-0054</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Dec. 18, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Bel Air</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1300 F Scottsdale Drive</b>			10f. Zip Code <b>21015</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>George (nmn) Mogg</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Maud Smith</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Wilbur F. Carr / Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1300 F Scottsdale Drive, Bel Air, Maryland 21015</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Deer Creek UMC Cem.</b>			Date <b>9/2/2011</b>	20c. Location - City or Town, State <b>Forest Hill, Maryland</b>	
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee <i>Charles A. Emery</i>			22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <b>years</b>					
	a. <i>Debilis</i> Due to (or as a consequence of):								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>6.1. Bleeding, cancer, heart failure, COPD, cerebrovascular disease</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>John J. Charles MD</i>					
				29c. License number <b>DS8307</b>			29d. Date signed (Month, Day, Year) <b>August 30 2011</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John J. Charles MD 6701 N. Charles ST Towson MD</b>			31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>					
State Registrar	32. Registrar's Signature <i>Emma S. Park</i>								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

COV

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28250

<b>Physician/ Medical Examiner</b>		1. For State Registrar 1. Decedent's Name (First, Middle, Last) <b>Jerry Curbs</b>										2. Date of Death Month Day Year <b>August 15, 2011</b>		3. Time of Death 0925 hrs							
<b>Funeral Director</b>		4a. Facility Name (if not institution, give street and number) <b>4001 Eastern Avenue Apt. 2</b>					4b. City, Town, or Location of Death <b>Baltimore</b>					4c. County of Death									
		5. Social Security Number <b>unk</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>66 Yrs.</b>		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (MM/DD/YYYY) <b>Oct 10, 1944</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>							
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b></b> 10c. City, Town or Location <b>Baltimore</b>										10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>									
		10e. Street and Number <b>4001 Eastern Avenue #2</b>					10f. Zip Code <b>21224</b>					10g. Citizen of What Country? <b>USA</b>									
		11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year of Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify: <b>white</b>					14. Race - American Indian, Black, White, etc.								
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unk</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) unk</b>					16b. Kind of Business/Industry <b>barber grooming</b>									
		17. Father's Name (First, Middle, Last) <b>unk</b>										18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Maccentelli</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>John Maccentelli/brother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4042 6th Street Baltimore, MD 21225</b>														
		20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify: in state</b>					20b. Place of Disposition (Name of cemetery, crematory or other place)					Date		20c. Location - City or Town, State							
		21. Signature of Funeral Service Licensee <b>Ronald S. Waze, Director</b>					22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>														
<b>Physician /Medical Examiner</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <b>Atherosclerotic Cardiovascular Disease complicated by Hyperthermia</b> Due to (or as a consequence of):										Approximate Interval Between Onset and Death									
		b. _____ Due to (or as a consequence of):																			
		c. _____ Due to (or as a consequence of):																			
		d. _____																			
		<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED																	
		IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year							
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown																			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
												24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene																	
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Aug 15, 2011</b>		28b. Time of Injury <b>0920 hrs</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject exposed to extreme environmental temperatures</b>											
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Townhouse / Rowhouse</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4001 Eastern Avenue Apt. 2, Baltimore, MD</b>											
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
		29b. Signature and title of certifier <b>Pamela E. Southall, MD Assistant Medical Examiner</b>		29c. License number <b>O.C.M.E.</b>										29d. Date signed (Month, Day, Year) <b>August 16, 2011</b>							
		30. Name and address of person who completed cause of death (Item 23a) <b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>																			
		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>[Signature]</b>																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 2825 |  
Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <b>08</b> Day <b>15</b> Year <b>2011</b>			3. Time of Death <b>1:50 AM</b>
Harry Couplin					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death <b>Havre de Grace</b>			4c. County of Death <b>Harford</b>
Citizen's Nursing Home					
5. Social Security Number <b>217-22-3623</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months <b>08</b> Days <b>15</b> Hours <b>00</b> Min. <b>00</b>	8. Date of Birth (Month, Day, Year) <b>Sept 9, 1925</b>
					9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Aberdeen</b>			10d. Inside City Limits <b>1 Yes 2 No</b>
10e. Street and Number <b>1913 Fletcher Street</b>		10f. Zip Code <b>21001</b>			10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>			unk 16b. Kind of Business Industry <b>construction</b>
17. Father's Name (First, Middle, Last)		unk			18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>
19a. Informant's Name/Relationship (Type, Print) <b>Citizens Care Center</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>415 S. Market Street Havre de Grace, MD 21078</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date
					20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Neuromuscular</b>			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):			
23d. Date of delivery Month Day Year					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Thomas A. King</b>		29c. License number <b>D42800</b>			29d. Date signed (Month, Day, Year) <b>8/18/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas A. King 251 Lewis Lane, Hale, NC, 21078</b>					
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>James A. Parker</b>			

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28252

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August Day 23 Year 2011		3. Time of Death 3:44 PM
<b>B. Carlton Couchoud</b>				
4a. Facility Name (If not institution, give street and number) <b>19B Heritage Ct.</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>577-48-4299</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>Nov 7, 1939</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>	
10d. Inside City Limits <b>Yes</b>				
10e. Street and Number <b>19B Heritage Court</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>unk</b>	unk	16b. Kind of Business/Industry <b>social security adm</b>
17. Father's Name (First, Middle, Last) <b>Jean Louis Couchoud</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Mae Ryman</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Louis Couchoud/brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11207 Brooklee Drive Upper Marlboro, MD 20772</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
21. Signature of Funeral Service U <b>Ronald J. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>days</b>		
a. <b>Cardiac Arrest</b> Due to (or as a consequence of): <b>Diseases</b>				
b. Due to (or as a consequence of): <b>coronary artery Disease</b>		<b>years</b>		
c. Due to (or as a consequence of):		<b>years</b>		
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <b>Anne M. MD</b>		29c. License number <b>046462</b>		29d. Date signed (Month, Day, Year) <b>25 Aug 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alma Weeks 1816 Bay Ridge Ave Annapolis MD 21401</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Suzanne J. Parker</b>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2011 28253

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>James Collins</b>							2. Date of Death Month Day Year <b>August 6, 2011</b>	3. Time of Death 4:45 Pm M	
	4a. Facility Name (if not institution, give street and number) <b>Riderwood Village</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
<b>Funeral Director</b>	5. Social Security Number <b>156-20-5234</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct 19, 1927</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>			
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>3118 Gracefield Road #CC420</b>				10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>'45-47</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>urban planner</b>			16b. Kind of Business Industry <b>public service</b>			
	17. Father's Name (First, Middle, Last) <b>Donald Woodruff Collins</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Elenor Olson</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Iris C. Antin/sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3144 Gracefield Road #GVT13 Silver Spring, MD 20904</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>John S. Wade, Director</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>	
	21. Signature of Funeral Service Licensee <b>John S. Wade, Director</b>									
	23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>									Approximate Interval Between Onset and Death <b>2 yrs</b>
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DM</b>									2 yrs
c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>COPD</b>									2 yrs	
d.										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>J. Harding</b>		29c. License number <b>R112633</b>			29d. Date signed (Month, Day, Year) <b>8/8/11</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Harding Riderwood Nursing Silver Spring, md</b>										
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Severa J. Parker</b>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit slip.

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28254

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Anna B. Campbell</b>				2. Date of Death Month <b>9</b> Day <b>2</b> Year <b>2011</b>	3. Time of Death <b>7:10 P M</b>				
	4a. Facility Name (if not institution, give street and number) <b>5521 Patrick Henry Dr.</b>		4b. City, Town, or Location of Death <b>Brooklyn Park, MD</b>		4c. County of Death <b>Anne Arundel</b>					
<b>Funeral Director</b>	5. Social Security Number <b>218-07-5191</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>92</b>	If Under 1 Year Months <b>02</b>	If Under 24 Hrs. Days <b>21</b>	8. Date of Birth (Month, Day, Year) <b>02/21/1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Brooklyn Park,</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			
	10e. Street and Number <b>5521 Patrick Henry Drive</b>			10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business Industry <b>Homemaker</b>				
	17. Father's Name (First, Middle, Last) <b>Robert Hensler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Love</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Sandra Tracy- Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1016 Wallace Road Crownsville, MD 21032</b>							
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial park</b>		Date <b>9/7/11</b>	20c. Location - City or Town, State <b>Parkville, MD</b>				
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <b>► M013604</b>		22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home 421 Crain Hwy S.E. Glen Burnie, MD 21061</b>							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Myelodysplastic Syndrome</b>						Approximate Interval Between Onset and Death <b>7.5 years</b>	
	Sequentially list conditions, if any, leading to the death cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>	
									24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>								26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>	
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>	28b. Time of injury <b>M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred				
									28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Glen Burnie, MD 21061</b>	
	29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D39505</b>						29d. Date signed (Month, Day, Year) <b>September 6, 2011</b>	
	29b. Signature and title of certifier <b>► Markman M.D.</b>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yudhish Markman 305 Hospital Dr, Glen Burnie, MD 21061</b>									
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>James J. Parker</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

# REPLACEMENT

11-06624

Aubrey Collins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28255

## 1- For State Registrar

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1345 hrs
<b>Audrey Mae Collins</b>		September 1, 2011

19069  
Funeral Director

4a. Facility Name (if not institution, give street and number) <b>3835 Cottage Avenue</b>	4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death <b>N/A</b>
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5. Social Security Number <b>214-40-2272</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>12/05/1943</b>	9. Birthplace (State or Foreign Country) <b>VA</b>
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Usual Residence of Decedent  
10a. State  
**MD** 10b. County  
**N/a** 10c. City, Town or Location  
**Baltimore**  
10d. Inside City Limits  
 Yes  No

10e. Street and Number <b>3835 Cottage Ave.</b>	10f. Zip Code <b>21215</b>	10g. Citizen of What Country? <b>U.S.A.</b>
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11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Date: <b>1968</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
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15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurse</b>	16b. Kind of Business/Industry <b>nursing home</b>
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17. Father's Name (First, Middle, Last) <b>Louis Gill</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Arlene Bullock</b>
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19a. Informant's Name/Relationship (Type, Print) <b>husband Genesis Collins Sr.</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3835 Cottage Ave., Baltimore, MD 21215</b>
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: <b>Woodlawn Cem.</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cem.</b>	Date <b>09/10/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
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21. Signature of Funeral Service Licensee <b>C. P. D.</b>	22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death)	a. <b>Complications Of Thermal Burns</b> Due to (or as a consequence of):
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
--	--

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED 1 as noted, 23a, pt. II, 27, 28a-f, per me, g923 1-18-12 sm
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9</b> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
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<b>Hypertensive Atherosclerotic Cardiovascular Disease;</b>	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Mitral valve regurgitation status post valve replacement</b>		
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<b>Chronic obstructive pulmonary disease; Diabetes Mellitus</b>		
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25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>fd 5-5-11</b>	28b. Time of Injury <b>fd 11:00 am</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>subject burned by assailant</b>
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28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>Residence</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3835 Cottage Ave. Baltimore, Md.</b>
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>(Check only one)</b>	29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier <b>Russell Alexander MD.</b>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 8, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>SEP 23 2011</b>	32. Registrar's Signature <b>S. J. Davis</b>
---	---

Baltimore, MD 21215-0036

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
The law requires that the death certificate be executed  
within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28256

**1 - For  
State  
Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Alma Lydia Drake</b>							2. Date of Death Month <b>Sept.</b> Day <b>4</b> , Year <b>2011</b>	3. Time of Death <b>7:45 AM</b>
	4a. Facility Name (if not institution, give street and number) <b>Madonna Heritage</b>			4b. City, Town, or Location of Death <b>Madonna</b>			4c. County of Death <b>Harford</b>		
<b>Funeral Director</b>	5. Social Security Number <b>153-18-6105</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>April 129, 1923</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Forest Hill</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>1708 Indigo Court</b>				10f. Zip Code <b>21050</b>			10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
<b>Baltimore, Maryland 21215-0036</b>	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>Nelson Edwin Nelson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lydia Ayre</b>						
<b>Physician/ Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Gary Drake - Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1708 Indigo Court, Forest Hill, MD 21050</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel &amp; Cremation Services</b>			Date <b>9-7-11</b>	20c. Location - City or Town, State <b>Forest Hill, MD</b>	
<b>To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Evans Funeral Chapel &amp; Cremation Services 3 Newport Drive, Forest Hill, MD 21050</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death  <b>days</b>  <b>weeks</b>  <b>years</b>  <b>years</b>					
<b>E.J.</b>	23b. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month <b>Day</b> <b>Year</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>CVD</b>  <b>CKD</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
<b>Division of Vital Records, P.O. Box 68760</b>	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>					
<b>3</b>	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
<b>State Registrar</b>	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <b>D31295</b>			29d. Date signed (Month, Day, Year) <b>9/7/11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wendy Kloczko ms 5701 Kenwood Ave Baltimore MD 21206</b>			31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature 		

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28257

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Arlene Desrochers</i>			2. Date of Death Month <input type="text"/> Sept. Day <input type="text"/> 03 Year <input type="text"/> 2011	3. Time of Death <input type="text"/> 1440 M
4a. Facility Name (if not institution, give street and number) <b>Howard County General Hospital</b>		4b. City, Town, or Location of Death <b>Columbia</b>		
4c. County of Death <b>Howard</b>				
5. Social Security Number <b>009-44-3684</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>
8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1920</b>		9. Birthplace (State or Foreign Country) <b>Vermont</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State <b>Maine</b>	10b. County <b>Cumberland</b>	10c. City, Town or Location <b>Bridgton</b>		
10e. Street and Number <b>44 North High Street</b>		10f. Zip Code <b>04009</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <input type="text"/>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business Industry <b>Own Home</b>
17. Father's Name (First, Middle, Last) <b>Harvey Somers</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Ingalls</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Rose Mahoney (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7708 E. Winterwood Ct., Severn, MD 21144</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Dennis J. Rawat</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Passumpsic Cemetery</b>	Date <b>9/9/2011</b>	20c. Location - City or Town, State <b>Waterford, VT</b>
21. Signature of Funeral Service Licensee <i>Dennis J. Rawat</i>		22. Name and Address of Facility <b>Sayles Funeral Home 525 Summer St., St. Johnsbury, VT 05819</b>		

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>metastatic colon cancer</b>			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. Due to (or as a consequence of): <i>metastatic colon cancer</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="text"/> <input type="checkbox"/> Unknown	23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number <b>00066515</b>		
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29b. Signature and title of certifier <i>N. Rawat M.D.</i>	29d. Date signed (Month, Day, Year) <b>Sep 03 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. Rawat M.D. 5755 Cedar La., Columbia, MD</b>	

31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature <i>James A. Garey</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 25 per me, g918,08/31/2011dhb Certificate of Death  
Registrar

Reg. No. 2011 28258

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>August L. DiGennaro</b>				2. Date of Death Month 8 Day 23 Year 2011		3. Time of Death 1:31 PM			
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Franklin Square Hospital</b>		4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>215-14-4040</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Mar 11, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
		Usual Residence of Decedent		10a. State MD 10b. County Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		10e. Street and Number <b>1011 Cedarcroft Rd.</b>		10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>United States</b>					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (14 or 5+)</b> 2 Produce Purveyor		16b. Kind of Business Industry <b>Cross Street Market</b>					
		17. Father's Name (First, Middle, Last) <b>Lou DiGennaro</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Unk</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Norma DiGennaro /Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>514 Crisfield Rd. Middle River, MD 21220</b>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>Aug 26, 2011</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>				
		21. Signature of Funeral Service Licensee <b>Rebecca Jackson</b>		22. Name of Cremation and Funeral Alternatives <b>8717 Green Pastures Drive Towson Maryland 21286</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death	
		a. <b>Cardiac Arrest</b> Due to (or as a consequence of):									
		b. <b>Massive Intracerebral Hemorrhage</b> Due to (or as a consequence of):									
		c. <b>Aspirin</b> Due to (or as a consequence of):									
		d. <b>Aspirin</b> Due to (or as a consequence of):									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>Res 0000</b>		29d. Date signed (Month, Day, Year) <b>8-23-2011</b>					
		29b. Signature and title of certifier <b>Asima Rahman</b>									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Asima Rahman 9000 Franklin Square Drive Baltimore, MD 21237</b>									
		31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>		32. Registrar's Signature <b>Leanna P. Parker</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28259

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Alvin Deminds</b>				2. Date of Death Month <b>8</b> Day <b>20</b> Year <b>2011</b>	3. Time of Death N/A	
4a. Facility Name (if not institution, give street and number) <b>University of Maryland</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		
4c. County of Death N/A						
5. Social Security Number <b>264424782</b>	6. Sex <b>M</b>	7. Age (In yrs. last birthday) Yrs. <b>70</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>July 20, 1941</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>		
10e. Street and Number <b>1351 Woodyear Street</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>10th Grade</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Sudden Death</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>		16b. Kind of Business Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>Alvin W. DeMinds</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Holmes</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sonya Smith - Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2928 Winchester Street Baltimore, MD. 21216</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>King Memorial Park</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>9/1/2011</b>	20c. Location - City or Town, State <b>Woodlawn, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Sonya Smith</b>				22. Name and Address of Facility <b>Chatman-Harris Funeral Home</b> <b>5240 Reisterstown Road Baltimore, MD. 21215</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sudden Death</b>				Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes</b>						
23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner		29c. License number <b>D62754</b>		29d. Date signed (Month, Day, Year) <b>Aug 20, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>22 South Greene St. Baltimore MD 21201</b>						
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Sonya S. Smith</b>				

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28260

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

William Durst 08/30/2011 1730 PM  
 Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certifier has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>William W. Durst</b>		2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2011</b>		3. Time of Death <b>1730p M</b>
4a. Facility Name (if not institution, give street and number) <b>127 Dihedrah Drive</b>		4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>218-30-0686</b>		6. Sex <input checked="" type="checkbox"/> XM <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months      Days      Hours      Min.
Usual Residence of Decedent <b>MD Baltimore</b>		8. Date of Birth (Month, Day, Year) <b>Aug. 21, 1934</b>		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>
10e. Street and Number <b>127 Dihedrah Drive</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Line Worker</b>		16b. Kind of Business/Industry <b>GM</b>
17. Father's Name (First, Middle, Last) <b>George Durst</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Carr</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Catherine McGowan/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>127 Dihedrah DRive Baltimore MD 21220</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>9/3/11</b>
21. Signature of Funeral Service Licensor 		22. Name and Address of Facility <b>300 Mace Ave. Balto. MD Connally Funeral Home of Essex 21221</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Arteriosclerotic Cardiovascular Disease</b>		
Sequentially list conditions, injury, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D18667</b>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>September 02, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip M. Lefebvre, MD 6 Trumble Hill Ct, Lutherville, MD 21093</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20a-c, 22, per th, g919 9-16-11 sm  
State of Maryland / Department of Health and Mental Hygiene

2011 28261

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Ursula Daniels		August 21, 2011		11:59 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Casey House		Rockville		Montgomery
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 14, 1939
579-66-8671				9. Birthplace (State or Foreign Country) Germany
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State MD	10b. County Montgomery	10c. City, Town or Location Gaithersburg		
10e. Street and Number 406 Girard Street #202			10f. Zip Code 20877	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) stenographer		16b. Kind of Business Industry Pepco
17. Father's Name (First, Middle, Last) Wiellie Warneke			18. Mother's Name (First, Middle, Maiden Surname) Alfred Wengel	
19a. Informant's Name/Relationship (Type, Print) Belinda Gripper/friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory	Date 9-6-2011	20c. Location - City or Town, State Glen Burnie, MD
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility Simplicity Crem & Funeral Service Thomas Allen P.A., 7090 Ridge Rd. Hanover, MD		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) left middle cerebral artery infarct				
Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): left middle cerebral artery infarct</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Hospice</i>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Bindu Joseph</i>		
		29c. License number D0060634		29d. Date signed (Month, Day, Year) Augu 22, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bindu Joseph Casey House Rockville md</i>				
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature <i>Karen S. Park</i>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28262

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Bernice Letha Frantz

2. Date of Death

Month Day Year  
September 3, 2011

3. Time of Death

5:40 p M

4a. Facility Name (if not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

225-10-3511

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

Month Day Year

Aug. 13, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

801 C Cashew Ct.

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business Industry

Accounting

17. Father's Name (First, Middle, Last)

James Tally Smith

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Magalina Smith

19a. Informant's Name/Relationship (Type, Print)

James Frantz / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3309 Forge Hill Rd., Street, MD 21154

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

20c. Location - City or Town, State

9-7-11

Towson, Maryland

21. Signature of Funeral Service Licensee

► Barbara J. Frantz  
McComas Funeral Home, P.A.  
50 W. Broadway, Bel Air, MD 21014

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEVERE AORTIC STENOSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► ATTENDING PHYSICIAN

29c. License number

J 0062239

29d. Date signed (Month, Day, Year)

SEPTEMBER 03 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURKIN NAILING CO., LTD  
UPPER CHESAPEAKE HOSPITAL BEL AIR, MD

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

Leanne S. Frantz

ORIGINAL

Division of Vital Records, P.O. Box 68760  
4-3-11 1740To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerFuneral  
Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician/  
Medical  
Examiner

FRANTZ, BERNICE

DHMH 17 Rev 7/2009

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28263

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Josephine Fenati</b>						2. Date of Death Month <b>08</b> Day <b>19</b> Year <b>2011</b>			3. Time of Death <b>5:05 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Lorien Assisted Living</b>			4b. City, Town, or Location of Death <b>Mount Airy</b>			4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>170-32-4089</b>		6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>96 Yrs.</b>	If Under 1 Year Months <b> </b> Days <b> </b>	If Under 24 Hrs. Hours <b> </b> Min. <b> </b>	8. Date of Birth (Month, Day, Year) <b>March 13, 1915</b>	9. Birthplace (State or Foreign Country) <b>PA</b>		
	Usual Residence of Decedent <b>Maryland Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>			10d. Inside City Limits <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>				
To Be Completed by Funeral Director	10e. Street and Number <b>713 Midway Ave.</b>			10f. Zip Code <b>21771</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <b>1 □ Never Married 2 □ Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>					
	17. Father's Name (First, Middle, Last) <b>Salvatore Brognano</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Pezzano</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Sam Fenati Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10817 Long Meadow Drive Damascus, MD 20872</b>			20c. Location - City or Town, State <b>2011 Neshannock Township, PA</b>			
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Castleview Mem. Gardens</b>			Date <b>Aug. 23,</b>				
	21. Signature of Funeral Service Licensee <b>Jeanne B. Carey</b>		22. Name and Address of Facility <b>Burrier-Queen Funeral Home &amp; Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death  <b>Failure to Thrive</b> Due to (or as a consequence of): <b>1 month</b>  <b>Dysphagia</b> Due to (or as a consequence of): <b>Many yrs.</b>  <b>Hypertension</b> Due to (or as a consequence of): <b>Many yrs.</b>  <b>Hyperlipidemia</b> Due to (or as a consequence of): <b>Many yrs.</b>			
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown</b>		23c. If yes, outcome pf pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 3 □ Probably 4 □ Unknown</b>			
							23f. Was an autopsy performed? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>			
							23g. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>			
	25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death Check only one <b>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 □ Residence 6 □ Other (Specify)</b>							
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>									
	29b. Signature and title of certifier <b>Nilay Thaker, D.O.</b>		29c. License number <b>H0070147</b>			29d. Date signed (Month, Day, Year) <b>8/19/11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nilay Thaker, D.O. 1502. S. Main St. Mt. Airy, MD 21771</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Suzanne D. Sparks</b>							

*Gregory Foster*  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For State Registrar		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e Per ANA BD G919 9/07/2011 JH											
		State of Maryland / Department of Health and Mental Hygiene Certificate of Death											
		Reg. No. 2011 28264											
Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Gregory Foster</i>											
		2. Date of Death Month Day Year 8 15 2011											
		3. Time of Death 00 50 M											
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>Suburban Hospital</i>											
		4b. City, Town, or Location of Death <i>Bethesda</i>											
		4c. County of Death <i>Montgomery</i>											
To Be Completed by Funeral Director		5. Social Security Number <i>578 60 1622</i>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>62</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
		8. Date of Birth (Month, Day, Year) <i>03 29 1941</i>											
		9. Birthplace (State or Foreign Country) <i>South Carolina</i>											
		10a. State <i>MD</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Capitol Heights</i>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		10e. Street and Number <i>Capitol Heights Blvd</i>				10f. Zip Code <i>20743</i>				10g. Citizen of What Country? <i>USA</i>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>black</i>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>0</i>				16b. Kind of Business Industry <i>truck driver</i>			
		17. Father's Name (First, Middle, Last) <i>George Foster</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Dawkins</i>							
		19a. Informant's Name/Relationship (Type, Print) <i>Carlton Foster/brother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>723 Capitol Heights Blvd Capitol Heights, MD 20743</i>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State		
		21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										Approximate Interval Between Onset and Death	
		a. <i>Hepatic Encephalopathy</i> Due to (or as a consequence of):											
		b. <i>Liver Failure</i> Due to (or as a consequence of):											
		c. <i>Liver Cirrhosis</i> Due to (or as a consequence of):											
		d.											
Physician/ Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hepatitis C, Thrombocytopenia, hypotension, Shock, hyponatremia</i>										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <i>D06840T</i>				29d. Date signed (Month, Day, Year) <i>08/15/2011</i>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jesus David Guerera-Nieto</i>				31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>				32. Registrar's Signature <i>Jesus D. Guerera</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N.

2011 28265

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

*Paula Feeheley*

2. Date of Death

Month Day Year

3. Time of Death

07:00 M

4a. Facility Name (if not institution, give street and number)

*Seasons Hospice of Baltimore*

4b. City, Town, or Location of Death

*Randallstown, MD*

4c. County of Death

*Baltimore*

5. Social Security Number

217-76-0609

6. Sex

1  M

2  F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb 1, 1963

9. Time of Death

Maryland

10. Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

8501 Summit Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 10

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Angie White

19a. Informant's Name/Relationship (Type, Print)

Warren Feeheley/former spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7462 Railroad Avenue Hanover, MD 21076

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Pancreatic Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

26. Place of Death (Check only one)

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence

6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes

2  No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D.O.

29c. License number

1764261

29d. Date signed (Month, Day, Year)

8/20/2011

31. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Betty Wang 6190 Georgetown Blvd., Eldersburg MD 21784

32. Registrar's Signature

Jeanne S. Powell

State Registrar

SEP 07 2011

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

## Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

1- For  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #8 Per FH G919 9/15/2011 JH

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28266

Physician/  
Medical  
Examiner

Funeral  
Director

Usual Residence of Decedent  
10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster  
10d. Inside City Limits 1  Yes 2  No

Important: If item 27 is marked other than "natural", or items 23 or 28-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

## To Be Completed by Funeral Director

## Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death M 12:01 A M
<i>Ruth Martha Feltman</i>		<i>September 6, 2011</i>		
4a. Facility Name (if not institution, give street and number) <i>45 W. Deep Run Road</i>		4b. City, Town, or Location of Death <i>Westminster</i>		4c. County of Death <i>Carroll</i>
5. Social Security Number <i>048-22-8228</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) <i>12/06/1929</i>
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) <i>CT</i>
10e. Street and Number <i>45 W. Deep Run Road</i>		10f. Zip Code <i>21158</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify <i>white</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business Industry <i>Own Home</i>
17. Father's Name (First, Middle, Last) <i>William Burnop</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Dorothy Crich</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Lynnellen Gray/Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>45 W. Deep Run Road, Westminster, MD 21158</i>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Dorota Marshall</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Atlantic crematory</i>		Date <i>9/8/2011</i>
21. Signature of Funeral Service Licensee <i>Babak Imanozi</i>		22. Name and Address of Facility <i>Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203</i>		20c. Location - City or Town, State <i>Glen Burnie, MD</i>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <i>Myocardial Infarction</i>				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation, Cerebrovascular Accidents, Peripheral Arterial Disease</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>Babak Imanozi</i>		29c. License number <i>H53939</i>		29d. Date signed (Month, Day, Year) <i>9/6/2011</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Babak Imanozi, 218 Wash. Heights Med. Ctr; Westminster, MD 21157</i>		31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		
		32. Registrar's Signature <i>Susan J. Parker</i>		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28267

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
DOD 9/3/11 TDD 1731  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
Me000510464  
Baltimore, Maryland 21215-0036  
DOD 9/3/11 TDD 1731  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>Lorraine S. Graham</b>		2. Date of Death Month Day Year <b>September 3, 2011</b>		3. Time of Death <b>5: 31 P.M.</b>
4a. Facility Name (if not institution, give street and number) <b>Upper Chesapeake Medical Center</b>		4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>348-14-4828</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month Day, year) <b>Mar. 5, 1923</b>
Usual Residence of Decedent <b>Maryland Harford</b>		10a. State <b>Maryland</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>298 B. Canterbury Road</b>		10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>Medical Assistant</b>		16b. Kind of Business Industry <b>Healthcare</b>
17. Father's Name (First, Middle, Last) <b>Willy Shurman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alma Muller</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Reed / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>527 Reckord Road Fallston, Maryland 21047</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Highview Mem. Gardens</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Highview Mem. Gardens</b>		20c. Location - City or Town, State <b>Fallston, Maryland</b>
21. Signature of Funeral Service Licensee <b>John L. Cawley</b>		22. Name and Address of Facility <b>Evans Funeral Chapel &amp; Cremation Service- BelAire 3 Newport Drive Forest Hill, Maryland 21050</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <b>Myocardial Infarction</b>		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Hyperlipidemia</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <b>Natural</b> 5 <input type="checkbox"/> Pending Investigation <b>Accident</b> 6 <input type="checkbox"/> Could not be determined <b>Suicide</b> <b>Homicide</b>
27. Manner of Death <b>Natural</b> 5 <input type="checkbox"/> Pending Investigation <b>Accident</b> 6 <input type="checkbox"/> Could not be determined <b>Suicide</b> <b>Homicide</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nursing Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>855143</b>		29d. Date signed (Month, Day, Year) <b>09/06/2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Karl Spector 2014 Tollgate Road Suite 200 Bel Air, MD 21015</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>James J. Parker</b>

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28268

Reg. No.

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carl Godfrey Gray</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>2011</b>		3. Time of Death <b>1040 p M</b>	
	4a. Facility Name (if not institution, give street and number) <b>Doctor's Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-76-5852</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <b>June 1, 1952</b>	9. Birthplace (State or Foreign Country) <b>Guyana</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Prince George's</b>				10c. City, Town or Location <b>Capitol Heights</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1005 Glen Willow Dr. #8</b>			10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>Guyana</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>(Unk)</b>			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business Industry <b>Building Maintenance</b>		
17. Father's Name (First, Middle, Last) <b>Oscar Gray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cynthia Henry</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margot Gray / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5612 Eagle St., Capitol Heights, MD 20743</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M00382</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>09/01/2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910</b>				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic liver Cancer</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>Unknown</b>
	b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 						
		29c. License number <b>D43446</b>						
		29d. Date signed (Month, Day, Year) <b>8-28-11</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROINTAN FARAH/FARAH 12150 Anapolis Road Suite 200 Glendale MD 20769</b>								
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 						

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Amend/2perphy g9199-16-11 d.6  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28269

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jacqueline W. Gandy</b>				2. Date of Death Month <b>September</b> Day <b>5</b> Year <b>2011</b>		3. Time of Death 1:15 AM			
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>Charlestown Care Center</b>			4b. City, Town, or Location of Death <b>Catonsville</b>			4c. County of Death <b>Baltimore</b>			
To Be Completed by Funeral Director	5. Social Security Number <b>380-20-5880</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Oct 23, 1925</b>	9. Birthplace (State or Foreign Country) <b>Michigan</b>		
	10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <b>Yes</b>		
	10e. Street and Number <b>10680 High Beam Ct.</b>				10f. Zip Code <b>21044</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <b>Never Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>Yes</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>No</b>			14. Race - American Indian, Black, White, etc. <b>White</b>		
								Specify:		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business Industry <b>Federal Government</b>					
17. Father's Name (First, Middle, Last) <b>Thomas L. Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cecilia F. Pearce</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Pamela Gandy /Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10680 High Beam Ct. Columbia, MD 21044</b>						
20a. Method of Disposition <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>Sep 07, 2011</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>					
21. Signature of Funeral Service Licensee <b>Lynda Lee Ritter M01443</b>		22. Name and Address of Facility <b>Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286</b>								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>AS CVD</b>								Approximate Interval Between Onset and Death <b>Years</b>	
	a. Due to (or as a consequence of):									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Myla Carpenter MD</b>		29c. License number <b>D 30989</b>			29d. Date signed (Month, Day, Year) <b>September 5 2011</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Myla Carpenter MD 711 Maiden Choice Ln Catonsville MD</b>										
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Laura J. Gandy</b>								

Baltimore, Maryland 21215-0036

Jacqueline Gandy  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28270

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irvin Oliver Glover

2. Date of Death

Month Day Year  
Aug. 26, 20113. Time of Death  
4:45 A MFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Future Care Lochern

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

5. Social Security Number

He 215-22-6350

6. Sex

 M

7. Age (In yrs. last birthday)

84

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

Month Day Year

Aug. 26, 2011

3. Time of Death

4:45 A M

Yrs.

Months

Days

Hours

Min.

Jan. 18, 1927

9. Birthplace (State or Foreign Country)  
Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

 Yes  No

10e. Street and Number

2501 Violet Avenue Apt. 302N

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Porter

16b. Kind of Business Industry

Maryland Jockey

17. Father's Name (First, Middle, Last)

K.C. Glover

18. Mother's Name (First, Middle, Maiden Surname)

Easter C. Garth

19a. Informant's Name/Relationship (Type, Print)

Clara D. Glover / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2501 Violet Avenue Apt 302N Baltimore, MD. 21215

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans Cem.

Date

9-6-2011

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Henry Hansen

22. Name and Address of Facility

Chatman-Harris Funeral Home

5240 Reisterstown Road Baltimore, MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Decline

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Progressive

Chronic Renal Failure

b. Due to (or as a consequence of):

Diabetes

c. Due to (or as a consequence of):

Peripheral Vascular Disease

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

Cirrhosis

Arterial Disease

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dawn S. Parker

29c. License number

D31464

29d. Date signed (Month, Day, Year)

9/2/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shanice A. Hashmi MD 821 N. Eutaw St Suite 308 Baltimore MD 21215

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

Dawn S. Parker

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 2827  
Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernice Eleanor Gray

2. Date of Death

Month Day Year  
August 20 2011

3. Time of Death

7:26 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

217-40-4243

6. Sex

M  F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month Day Year)

Sept. 28, 1940

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

6310 Greenspring Avenue Apt. T4

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurses Aide

16b. Kind of Business/Industry

Baltimore City Health Dept.

17. Father's Name (First, Middle, Last)

William Francis Tyler, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lucille Emerson

19a. Informant's Name/Relationship (Type, Print)

Brenda Curry - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6310 Greenspring Avenue Apt. 404 Baltimore, Maryland 21209

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

8/31/2011

20c. Location - City or Town, State

Lansdowne, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Chatman-Harris Funeral Home  
5240 Reisterstown Road Baltimore, MD. 21215

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

A acute Myocardial Infarction

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.  
b.  
c.  
d.

Due to (or as a consequence of):  
Congestive Heart Failure

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  
 Pregnant at time of death  
 Unknown

3  Ectopic pregnancy  
5  Other (Specify)

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient

ER/Outpatient

DOA

Other:

Nursing Home

Residence

Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

Natural  
 Accident  
 Suicide  
 Homicide

5  Pending investigation  
6  Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M  Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 005448 2

29d. Date signed (Month, Day, Year)

August 20, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Patrick McKinley M.D., Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28272

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Joseph Gontasz</b>			2. Date of Death Month Day Year <b>September 4 2011 12:18 PM</b>			3. Time of Death <b>12:18 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>2713 Creston Road</b>			4b. City, Town, or Location of Death <b>Dundalk</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>219-20-6914</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>June 22 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Dundalk</b>		
	10e. Street and Number <b>2713 Creston Road</b>			10f. Zip Code <b>21222</b>			10g. Citizen of What Country? <b>C. S. A.</b>		
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No 1944 If Yes, Give Year or Dates: 1946</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Compound Miner</b>			16b. Kind of Business/Industry <b>American Can</b>			
	17. Father's Name (First, Middle, Last) <b>Anthony Gontasz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Senko</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Theresa Gontasz (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2713 Creston Road Dundalk, Maryland 21222</b>						
Physician /Medical Examiner	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ostlund Cemetery</b>		Date <b>September 4, 2011</b>	20c. Location - City or Town, State <b>East Point Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Mark O Chynacki</b>		22. Name and Address of Facility <b>W. DABROWSKI, Chojnacki Funeral Home P.A. 1005 Dundalk Ave. Baltimore, Maryland 21222</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		Metastatic Renal Carcinoma (presumed)			Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>tobacco use</b>					23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			23f. Was an autopsy performed? <b>1 Yes 2 No</b>			
	27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>M</b>	28b. Time of Injury <b>1 Yes 2 No</b>	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>Phatak M.D.</b>		29c. License number <b>D56466</b>			29d. Date signed (Month, Day, Year) <b>9/6/2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SWATI PHATAK 2112 Dundalk Ave Dundalk 21112</b>								
	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Sandeep J. Phatak</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28273

1. For State  
Registrar**Physician/  
Medical Examiner**

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>Autumn Anne Hickey</b>				2. Date of Death Month Day Year <b>August 29, 2011</b>	3. Time of Death 0248 hrs
4a. Facility Name (if not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre De Grace</b>	
				4c. County of Death <b>Harford</b>	
5. Social Security Number <b>216-92-2988</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>32</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>12/04/1978</b>
			Yrs.		9. Birthplace (State or Foreign Country) <b>MD</b>

**Funeral Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**10a. State  
**MD**10b. County  
**Cecil**10c. City, Town or Location  
**Port Deposit**10d. Inside City Limits  
 Yes  No10e. Street and Number  
**82 A North Main St.**10f. Zip Code  
**21904**10g. Citizen of What Country?  
**USA**

11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify:
--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Chef</b>	16b. Kind of Business/Industry <b>Hospitality</b>
---	---	--

17. Father's Name (First, Middle, Last) <b>David Foster Hickey</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Ann Staubs</b>
---	---

19a. Informant's Name/Relationship (Type, Print) <b>Ruth Ann Clover/Mother</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>82 A North Main St. Port Deposit, MD 21904</b>
---	--

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>	Date <b>Sept 2, 2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>
---	---	-----------------------------	--

21. Signature of Funeral Service Licensee <b>Rebecca Hocherman</b>	22. Name and Address of Facility <b>CAFA/Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286</b>
---	--

**Physician/  
Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	<b>a. Cirrhosis and Steatosis of the liver</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
--	--	--	--

<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	<b>23a.pt.II,27,per me,g920 10-26-11 sm</b>	Approximate Interval Between Onset and Death
---	---	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
<b>Chronic alcohol use</b>	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:
---	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc.
				28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
---

29b. Signature and title of certifier 	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 29, 2011</b>
---	--	---

30. Name and address of person who completed cause of death (Item 23a) <b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
--

31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature 
---	-------------------------------

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28274  
Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALBERT HEISE</b>							2. Date of Death Month <b>09</b> Day <b>04</b> Year <b>2011</b>	3. Time of Death <b>1151 AM</b>		
	4a. Facility Name (if not institution, give street and number) <b>Seasons Hospice</b>				4b. City, Town, or Location of Death <b>Randallstown</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>213-18-3381</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>7/11/1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Randallstown</b>					10d. Inside City Limits <b>Yes</b>			
	10e. Street and Number <b>3612 Edgewood Rd.</b>		10f. Zip Code <b>21133</b>				10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Ward Machinery</b>						
	17. Father's Name (First, Middle, Last) <b>Willy Heise</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Alma Guessing</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Doris F. Heise/Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3612 Edgewood Rd., Randallstown, MD 21133</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>Woodlawn, MD</b>				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Burier-Queen Funeral Home &amp; Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784</b>							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): <b>Myocardial Infarction</b> b. Due to (or as a consequence of): <b>Respiratory Failure</b> c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice Inpatient Unit</b>								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D67220</b>		29d. Date signed (Month, Day, Year) <b>09/04/2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Adele Agar, MD 283 Smith Ave. #203, Baltimore, MD</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28275

**1- For State Registrar**

Reg. No.

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0221 hrs
<b>Teresa Holbrook</b>	September 2, 2011	

4a. Facility Name (if not institution, give street and number) <b>1 Banca Place</b>	4b. City, Town, or Location of Death <b>Middle River</b>	4c. County of Death <b>Baltimore County</b>			
5. Social Security Number <b>219-04-8455</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>43 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>Jan. 21, 1968</b>	9. Birthplace (State or Foreign Country) <b>MD</b>

10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Middle River</b>	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number <b>1 Banca Place</b>	10f. Zip Code <b>21220</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
--	---	---	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>	16b. Kind of Business/Industry <b>Port City Press</b>
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17. Father's Name (First, Middle, Last) <b>Robert Blankenship</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Thompson</b>
--	--

19a. Informant's Name/Relationship (Type, Print) <b>Robert Blankenship/father</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Banca Place Baltimore MD 21220</b>
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Bayview Crematory</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>	Date <b>9/6/11</b>	20c. Location - City or Town, State <b>Baltimore MD</b>
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21. Signature of Funeral Service Licensee <i>H. Titus A. Titus</i>	22. Name and Address of Facility <b>Connelly Funeral Home of Essex 21221</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <b>Diabetic Ketoacidosis</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	Approximate Interval Between Onset and Death
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<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g919 9-13-11 sm	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

<b>Atherosclerotic Cardiovascular Disease</b>		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene
---	--	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>J.M. Titus</i>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 3, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature <i>James A. Titus</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28276

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Nelson Oliver Hower</b>				2. Date of Death Month Day Year <b>July 28, 2011</b>				3. Time of Death <b>10:15 AM</b>				
4a. Facility Name (If not institution, give street and number) <b>8125 Potomac Landing Drive</b>				4b. City, Town, or Location of Death <b>Port Tobacco</b>				4c. County of Death <b>Charles</b>				
5. Social Security Number <b>215-80-5279</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>50 Yrs.</b>	If Under 1 Year Months Days Hours Min.		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year) <b>Feb 4, 1961</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Charles</b>				10c. City, Town or Location <b>Port Tobacco</b>						10d. Inside City Limits 1 Yes 2 No <b>X</b>		
10e. Street and Number <b>8125 Potomac Landing Drive</b>				10f. Zip Code <b>20677</b>				10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>unk</b>		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced If Yes, Give Year or Dates: <b>unk</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>unk</b>			14. Race: American Indian, Black, White, etc. Specify: <b>white</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cabinet maker</b>						16b. Kind of Business/Industry <b>manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Rolland Oliver Hower</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Harryette Bradley</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Don DeHanas/friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8125 Potomac Landing Drive Port Tobacco, MD 20677</b>								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>unk</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>								
23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 years</b>		
<p>a. Due to (or as a consequence of): <b>Head + neck Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				<b>5 <input type="checkbox"/> Pending investigation</b>		<b>6 <input type="checkbox"/> Could not be determined</b>						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>												
29b. Signature and title of certifier <b>M. A. SHAFI AF MEELU</b>				29c. License number <b>D 462 46</b>						29d. Date signed (Month, Day, Year) <b>August 22, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SEP 07 2011</b>				32. Registrar's Signature <b>Patricia B. Parker</b>						31. Date filed (Month, Day, Year) <b>Walldorf MD 20603</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend items 5,7-18 per th g919 9-8-11 vt

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28277

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Year		3. Time of Death 11:30 AM
<i>Mary Louise Houston</i>		<i>August 31 2011</i>		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Howard County General Hospital</i>		<i>Columbia</i>		<i>Howard County</i>
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i>	If Under 1 Year Months Days Hours Min.
<i>214-22-9160</i>				
10a. State <i>MD.</i>		10b. County <i>MD.</i>		10c. City, Town or Location <i>Baltimore</i>
10e. Street and Number <i>1115 Wheeler Avenue</i>		10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. <input type="checkbox"/> Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>12th</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Maintenance</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Seconday (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Garrison Forest</i>		16b. Kind of Business Industry <i>Westinghouse</i>
17. Father's Name (First, Middle, Last) <i>James Dwight McLurkin</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Ethel McLurkin</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Johnson Thomas McLurkin (Brother)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10968 Eight Bells Ln., Columbia, MD 21044</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Garrison Forest</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest</i>		Date <i>9-9-2011</i>
21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>		22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 5151 Balto. National Pike (21229)</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Acute Myocardial Infarction Pulmonary edema</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9</i> <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D30641</i>		
29b. Signature and title of certifier <i>Ramesh Sabapathy</i>		29d. Date signed (Month, Day, Year) <i>AUG 31, 2011 1700</i>		
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Laura J. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28278

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>MARGARET HARRIS</b>				2. Date of Death Month <b>09</b> Day <b>08</b> Year <b>2011</b>		3. Time of Death <b>1245 AM</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Northwest Seasons Hospice</b>		4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Balto.</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>218-28-0381</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs./last birthday) <b>81 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>8-24-1930</b>	9. Birthplace (State or Foreign Country) <b>Illinois</b>	10d. Inside City Limits <b>1 Yes 2 No</b>
To Be Completed by Physician/Medical Examiner		Usual Residence of Decedent <b>Md Balto.</b>		10c. City, Town or Location <b>Randallstown</b>		10f. Zip Code <b>21173</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
To Be Completed by Physician/Medical Examiner		11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>	
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>X Ray Tech</b>		16b. Kind of Business/Industry <b>Hospital</b>			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>John Wells</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Saunders</b>					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Debbie Faulk daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9221 Samoset Rd., Randallstown, Md. 21133</b>					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Cem. 9-13-2011</b>		Date <b>9-13-2011</b>	20c. Location - City or town, State <b>Balto. Md.</b>		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Carlton C. Daugler</b>		22. Name and Address of Funeral Service P.A. <b>Carlton C. Daugler's Funeral Service P.A. 1701 McCullough St., Balto. Md. 21217</b>					
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Colon Cancer</b>		23b. Due to (or as a consequence of): <b>a. Colon Cancer</b>				Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ c. _____ d. _____					
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
To Be Completed by Physician/Medical Examiner						24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> <b>HOSPICE INPATIENT</b>					
To Be Completed by Physician/Medical Examiner		27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <b>Adeel Azeal</b>		29c. License number <b>D67220</b>		29d. Date signed (Month, Day, Year) <b>09/08/2011</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 22a, type, Print) <b>Adeel Azeal, MD, 2835 South Ave. # 203, Baltimore, MD 21209</b>		32. Registrar's Signature <b>Susan B. Farrel</b>					
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Susan B. Farrel</b>					

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

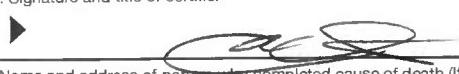
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28279

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

		1. Decedent's Name (First, Middle, Last) <b>Thomas F. Hall</b>				2. Date of Death Month Day Year <b>August 17 2011</b>		3. Time of Death 12:16 PM		
		4a. Facility Name (if not institution, give street and number) <b>Fahrney-Keedy Memorial Home</b>				4b. City, Town, or Location of Death <b>Boonsboro</b>		4c. County of Death <b>Washington</b>		
5. Social Security Number <b>178-26-8961</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year) <b>Dec 27, 1931</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number <b>13915 Paradise Church Road</b>						10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>'50-53</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b></b>				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>		16b. Kind of Business Industry <b>engineer</b>						<b>unk</b>
17. Father's Name (First, Middle, Last) <b>Harry Hall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Louise Matlack</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Kevin Spessard/son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Key Circle Hagerstown, MD 21740</b>								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <b>Chronic obstructive Pulmonary Disease</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>20y</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Hypertensive cardiovascular Disease</b> Due to (or as a consequence of):						<b>20y</b>		
		c. <b>Diabetes Mellitus</b> Due to (or as a consequence of):						<b>20y</b>		
d.										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number <b>DS 2323</b>				29d. Date signed (Month, Day, Year) <b>08-17-2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Khaled Waseem, MD 1126 Opal Court Hagerstown, MD 21740</b>										
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 								

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Important: If item 27 is marked other than "natural", or items 23a or 28a if show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Medical Certificate: To Be Completed by Physician/Medical Examiner

## To Be Completed by Funeral Director

Thomas F. Hall  
Baltimore, Maryland 21215-0036

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28280

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gary R. Hutson

2. Date of Death

Month Day Year

September 4, 2011

3. Time of Death

2:40 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

216 Holy Cross Road

4b. City, Town, or Location of Death

Brooklyn

4c. County of Death

Anne Arundel

5. Social Security Number

214-40-7028

6. Sex

M  F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06/24/1942

9. Birthplace (State or Foreign Country)

MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

Yes  No

10e. Street and Number

216 Holy Cross Road

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates: Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Line Worker

16b. Kind of Business/Industry

Manufacture

17. Father's Name (First, Middle, Last)

Edward Hutson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel May Simmont

19a. Informant's Name/Relationship (Type, Print)

Blanche Hutson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 Holy Cross Road, Brooklyn, MD 21225

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheasapeake crematory

Date

9/8/2011

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services

PO Box 1413, Baltimore, MD 21203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

10 yrs

a. Congestive Heart Failure

Due to (or as a consequence of):

Cardiomyopathy

5 yrs

b. Due to (or as a consequence of):

Atrial Fibrillation

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

Natural  Pending investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?  
 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0052205

29d. Date signed (Month, Day, Year)

09/06/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pratibha Sharma, 3001 S. Hanover Street, Baltimore, MD 21225

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend Items 25 per me, g918,08/31/2011ahb

Certificate of Death

Reg. No. 2011 28282

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Alison Jones</i>				2. Date of Death Month Day Year <i>August 10 2011</i>		3. Time of Death <i>1449 P M</i>			
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>The Johns Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>NA</i>			
To Be Completed by Funeral Director		5. Social Security Number <i>214-86-0112</i>		6. Sex <i>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</i>	7. Age (In yrs. last birthday) <i>48 Yrs.</i>	If Under 1 Year Months <i>09</i>	If Under 24 Hrs. Days <i>18</i>	8. Date of Birth (Month Day Year) <i>09-18-62</i>	9. Birthplace (State or Foreign Country) <i>MD</i>		
		Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>NA</i>				10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <i><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	
		10e. Street and Number <i>342 Elrino Street 2nd. Floor</i>				10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>USA</i>			
		11. Marital Status <i>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify.</i>		14. Race - American Indian, Black, White, etc. <i>African American</i>			
		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 8th Grade</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) NA Domestic</i>		16b. Kind of Business Industry <i>Home maker</i>					
		17. Father's Name (First, Middle, Last) <i>James Thomas</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Jean Ann Jones</i>					
		19a. Informant's Name/Relationship (Type, Print) <i>Vaneka Powers-Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>714 N. Madeira Street Baltimore, MD 21205</i>							
		20a. Method of Disposition <i>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cem.</i>		Date <i>08-16-11</i>	20c. Location - City or Town, State <i>Lansdowne, MD</i>				
		21. Signature of Funeral Service Licensee <i>Wylie</i>		22. Name and Address of Facility <i>Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217</i>							
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
		<p>a. <i>Intracerebral hemorrhage</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <i>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</i>		23c. If yes, outcome of pregnancy <i>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</i>		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</i>	
										24a. Was an autopsy performed? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>	24b. Were autopsy findings available prior to completion of cause of death? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>
		25. Was case referred to medical examiner? <i>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>		26. Place of Death (Check only one) Hospital: <i>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DODA</i> Other:		23d. Date of delivery Month Day Year					
		27. Manner of Death <i>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</i>		28a. Date of injury (Month, Day, Year) <i>28b. Time of injury M</i>	28c. Injury at work? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>City or Town, State</i>					
		29a. Certifier <i>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>									
		29b. Signature and title of certifier <i>m. m. m.</i>		29c. License number <i>D 40167</i>		29d. Date signed (Month, Day, Year) <i>August 10 2011</i>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark A. Miske 600 North Wolfe St. Baltimore, MD 21287</i>									
Division of Vital Records, P.O. Box 68760		31. Date filed (Month, Day, Year) <i>AUG 31 2011</i>		32. Registrar's Signature <i>Leanne S. Parker</i>							

ORIGINAL

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28283

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ax

1. Decedent's Name (First, Middle, Last) <b>Jesse Berkley Jacobs, III</b>				2. Date of Death Month <b>September</b> Day <b>04, 2011</b> Year	3. Time of Death <b>4:23 PM</b>		
4a. Facility Name (if not institution, give street and number) <b>11 Nightingale Way Apt.B7</b>				4b. City, Town, or Location of Death <b>Lutherville</b>			
4c. County of Death <b>Baltimore County</b>							
5. Social Security Number <b>217-40-5225</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day, Year) <b>Feb. 18, 1942</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, MD.</b>
10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Lutherville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>11 Nightgale Way</b>		10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>Peacetime</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>N/A</b>		16b. Kind of Business Industry <b>Restaurant Owner</b>			Food Service
17. Father's Name (First, Middle, Last) <b>Jesse Berkley Jacobs, II</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Loretta Redman</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Patricia Ann(nee Matthews)</b> (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Nightingale Way Apt.B7 Lutherville, MD. 21093</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel and Cremation Services, Inc.</b>		Date <b>Wednesday, Sept. 07, 2011</b>	20c. Location - City or Town, State <b>(Harford County) Forest Hill, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair, Sr. CFSP</b> <i>Jeffrey L. Gair, Jr.</i>		22. Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A.</b> <b>2325 York Road Timonium, Maryland 21093-2215</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Bladder Cancer</b>							
Approximate Interval Between Onset and Death <b>Four Years</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Mei Tang, MD.</i>		29c. License number <b>D 0069329</b>		29d. Date signed (Month, Day, Year) <b>Sep. 6, 2011</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mei Tang, MD. 6569 N. Charles St; Suite 201; Baltimore, MD 21204</b>							
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>Barbara J. Parker</i>					

State  
Registrar

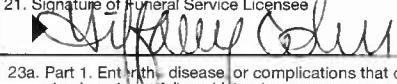
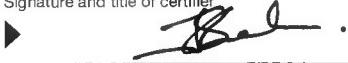
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28284

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Just</b>				2. Date of Death Month Day Year <b>September 02, 2011</b>	3. Time of Death 9:10P M	
	4a. Facility Name (if not institution, give street and number) <b>Manor Care Rossville</b>		4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>216-07-9427</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (in yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months <b>5</b>	If Under 24 Hrs. Days <b>21</b>	8. Date of Birth (Month Day Year) <b>MAY 21, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
10e. Street and Number <b>8615 Ellen Court</b>			10f. Zip Code <b>21234</b>			10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business Industry <b>Amalgamated Clothing</b>	
17. Father's Name (First, Middle, Last) <b>Unk.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unk.</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Louise Tricario (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5020 White Marsh Road Baltimore, Maryland 21237</b>				
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>			Date <b>September 07, 2011</b>	20c. Location - City or Town, State <b>Timonium, Maryland</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Evans Funeral Chapel &amp; Cremation Services Parkville 8801 Harford Road Parkville, Maryland 21231</b>				
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>cerebrovascular disease accident</b>							
Approximate Interval Between Onset and Death							
a. Due to (or as a consequence of): <b>Atherosclerotic Heart disease.</b>							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>							
24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>							
24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>							
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> <b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. Signature and title of certifier 				29c. License number <b>D 69540</b>		29d. Date signed (Month, Day, Year) <b>09/06/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jigar Shah, 8813 Waltham Woods Rd Suite 204 Parkville MD 21234</b>							
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 					

Helen Just

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20a-c, 22, per fh, g919 9-16-11 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28285

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Rowena W. Jones</b>				2. Date of Death Month Day Year <b>August 25 2011</b>		3. Time of Death <b>7:45 A.M.</b>			
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Baltimore Washington Med Ctr</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>215-82-5002</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b>0 0 0 0</b>	8. Date of Birth (Month, Day, Year) <b>May 13, 1963</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>				10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number <b>406 Pamela Road #B</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>black</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>geriatric nursing</b>		16b. Kind of Business Industry <b>healthcare</b>			
		17. Father's Name (First, Middle, Last) <b>Marion Wilkerson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Constance Smith</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Michael Jones/spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>406 Pamela Road #B Glen Burnie, MD 21061</b>					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>		Date <b>9-15-11</b>	20c. Location - City or Town, State <b>Glen Burnie, MD</b>		
		21. Signature - Physician/Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>Simplicity Crem &amp; Funeral Services</b> <b>Thomas Allen, P.A. 7090 Ridge Rd Hanover, MD, 21076</b>					
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death	
		<p>a. Due to (or as a consequence of): <b>lepticemia</b></p> <p>b. Due to (or as a consequence of): <b>endo carditis</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9</b> <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus end stage renal failure</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>August 25 2011</b>		28b. Time of injury M <b>M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>D 43977</b>				29d. Date signed (Month, Day, Year) <b>August 25 2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Constance Smith - 301 Hospital Drive, Glen Burnie, MD 21061</b>				31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>				32. Registrar's Signature <b>Leanne J. Ball</b>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28286

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth Peter Johnson M.D.</b>					2. Date of Death Month 09 Day 03 Year 2011	3. Time of Death 5:48 PM		
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>107-24-2505</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 12 1932</b>	9. Birthplace (State or Foreign Country) <b>New York</b>		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Lutherville Timonium</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>49 Seminary Farm Road</b>			10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Physician</b>		16b. Kind of Business/Industry <b>Health Care</b>				
	College (1-4 or 5+) <b>5+</b>								
	17. Father's Name (First, Middle, Last) <b>Kenneth P. Johnson Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nina Bengtson</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Jacquelyn Johnson - WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21093</b> 49 Seminary Farm Road Lutherville Timonium MD					
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Peter M. Fleming</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>		Date <b>09-06-2011</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Services Licensee		22. Name and Address of Facility <b>Cremation Society Of Maryland INC</b> 299 Frederick Road, Baltimore MD 21228						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>Multiple Myeloma</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b> <b>Dementia</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		M.D.		29c. License number <b>D0071287</b>		29d. Date signed (Month, Day, Year) <b>9-4-11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28287

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Evelyn James</i>					2. Date of Death Month <input type="text"/> August Day <input type="text"/> 26 Year <input type="text"/> 2011	3. Time of Death <input type="text"/> 1145 A M																																	
	4a. Facility Name (if not institution, give street and number) <i>Seasons Hospice @ Northwest Hospital</i>					4b. City, Town, or Location of Death <i>Randallstown</i>	4c. County of Death <i>Baltimore</i>																																	
Funeral Director	5. Social Security Number <b>213-32-9164</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) <b>Sept. 23, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>																																	
	10a. State <b>Maryland</b>					10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																
To Be Completed by Funeral Director	10e. Street and Number <b>4023 Lewiston Avenue</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>																																		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>Black</b>																																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> <b>3 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registrar</b>			16b. Kind of Business/Industry <b>Johns Hopkins School of Medicine</b>																																		
	17. Father's Name (First, Middle, Last) <b>Wallace K. Ware</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Thornton</b>																																				
	19a. Informant's Name/Relationship (Type, Print) <b>Wendy James-Johnson/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3801 Bartwood Road Baltimore, Maryland 21215</b>																																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>9/2/11</b>	20c. Location - City or Town, State <b>Woodlawn, MD</b>																																	
	21. Signature of Funeral Service Licensee <i>Jerry Harris</i>			22. Name and Address of Facility <b>Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215</b>																																				
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																							
	<table border="1"> <tr> <td>a. <i>Hepato renal syndrome</i> Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>b. <i>End Stage Liver Disease</i> Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> </table>								a. <i>Hepato renal syndrome</i> Due to (or as a consequence of):								b. <i>End Stage Liver Disease</i> Due to (or as a consequence of):								c. _____ Due to (or as a consequence of):								d. _____ Due to (or as a consequence of):							
a. <i>Hepato renal syndrome</i> Due to (or as a consequence of):																																								
b. <i>End Stage Liver Disease</i> Due to (or as a consequence of):																																								
c. _____ Due to (or as a consequence of):																																								
d. _____ Due to (or as a consequence of):																																								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>																																	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																																							
	<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																																							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																							
	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Inpatient Hospice																																							
	26. Place of Death (Check only one)																																							
	27. Manner of Death <table border="1"> <tr> <td><input type="checkbox"/> Natural</td> <td><input type="checkbox"/> Pending Investigation</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td><input type="checkbox"/> Could not be determined</td> </tr> <tr> <td><input type="checkbox"/> Suicide</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td></td> </tr> </table>								<input type="checkbox"/> Natural	<input type="checkbox"/> Pending Investigation	<input type="checkbox"/> Accident	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Suicide		<input type="checkbox"/> Homicide																									
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<input type="checkbox"/> Homicide																																								
	28a. Date of injury (Month, Day, Year) <input type="text"/> 28b. Time of injury M <input type="text"/> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No																																							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																																							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)																																							
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																							
	29b. Signature and title of certifier <i>Dorothy Sean</i>																																							
	29c. License number <b>D0053337</b>																																							
	29d. Date signed (Month, Day, Year) <b>August 27 2011</b>																																							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dorothy Sean md 2835 Smith Avenue Ste 203 Baltimore Md 21204</b>																																							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>																																							
	32. Registrar's Signature <i>S. Sauer</i>																																							

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28288

Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
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Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For State Registrar		2. Date of Death Month Day Year		3. Time of Death Hour Minute	
1. Decedent's Name (First, Middle, Last) <b>BETTY LOU JONES</b>		4b. City, Town, or Location of Death <b>Darlington</b>		4c. County of Death <b>Harford</b>	
4a. Facility Name (if not institution, give street and number) <b>Country View Assisted Living</b>		4b. City, Town, or Location of Death <b>Darlington</b>		4c. County of Death <b>Harford</b>	
5. Social Security Number <b>215-34-8273</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>74</b>	
8. Date of Birth (Month, Day, Year) <b>July 10, 1937</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Forest Hill</b>	
10e. Street and Number <b>1700 Lasalle Road</b>		10f. Zip Code <b>21050</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry <b>School Bus Attendant</b>	
17. Father's Name (First, Middle, Last) <b>Jesse Shobert Amos</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Mae Meeks</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Connie L. Hoffman / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1700 Lasalle Road, Forest Hill, MD 21050</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Bel Air Memorial Gdn.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gdn.</b>		Date <b>9-9-11</b>	20c. Location - City or Town, State <b>Bel Air, Maryland</b>
21. Signature of Funeral Service Licensee <b>Stefan A. Negley</b>		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Cerebral Thrombosis</b>		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospital</b>		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1700 Lasalle Road, Forest Hill, MD 21050</b>	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>John D. Parker MD</b>		29c. License number <b>D15872</b>		29d. Date signed (Month, Day, Year) <b>Sept 6 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John D. Parker</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>John D. Parker</b>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death2011 28289  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darron Johnson</b>							2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>2011</b>	3. Time of Death <b>0220 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death			
Funeral Director	5. Social Security Number <b>infant</b>		6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) Yrs. Months <b>1</b> Days <b>57</b>		If Under 1 Year Hours <b>1</b> Min. <b>57</b>	8. Date of Birth (Month, Day, Year) <b>Aug 24, 2011</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1 X Yes 2 □ No</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>4404 Franconia Avenue</b>			10f. Zip-Code <b>21206</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No</b> Specify: <b>black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) infant</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) infant</b>		16b. Kind of Business/Industry <b>infant</b>					
	17. Father's Name (First, Middle, Last) <b>Darron Green</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Stephanie Johnson</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Johns Hopkins Bayview Med Ctr</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4940 Eastern Avenue Baltimore, MD 21224</b>					
	20a. Method of Disposition <b>1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 X Other (Specify) <b>in state</b></b>		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 hours</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. <b>Prematurity</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 X No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) <b>9 □ Unknown</b></b>					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>	
	25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>			27. Manner of Death <b>1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <b>1 □ Yes 2 □ No</b> 28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>Meghan Pratt</b>							
	29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 24, 2011</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Meghan Pratt</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b> 32. Registrar's Signature <b>Susan J. Parker</b>							
State Registrar	4940 Eastern Avenue, Baltimore, MD, 21224									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 25, per me, g919 9-13-11 sm

State of Maryland / Department of Health and Mental Hygiene

2011 28290

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	Harold Jones		2. Date of Death Month Day Year	3. Time of Death M
--	--------------	--	------------------------------------	-----------------------

4a. Facility Name (if not institution, give street and number)	The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City	4c. County of Death
--	----------------------------	--	--	---------------------

5. Social Security Number 049-22-1239	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 16, 1930	9. Birthplace (State or Foreign Country) unk
--	--	---	---	--	---

Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
-----------------------------	--	--	--

10a. State MD	10b. County	10c. City, Town or Location Baltimore	10g. Citizen of What Country? USA
------------------	-------------	--	--------------------------------------

11. Marital Status unk	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: black
---------------------------	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) unk	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) unk	16b. Kind of Business Industry unk
--	---	---------------------------------------

17. Father's Name (First, Middle, Last) Johns Hopkins Hospital	unk	18. Mother's Name (First, Middle, Maiden Surname) unk
---	-----	--

19a. Informant's Name/Relationship (Type, Print) Johns Hopkins Hospital	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 n. Wolfe Street Baltimore, MD 21287
--	--

20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
--	--	------	-------------------------------------

21. Signature of Funeral Service Licensee Ronald S. Wade, Director	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
---	--

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. Respiratory insufficiency Due to (or as a consequence of):	
b. Intracranial hemorrhage Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	---

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier Tomas Garzon M.D.	29c. License number RGS-000	29d. Date signed (Month, Day, Year) August 25, 2011
--	--------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tomas Garzon M.D.	600 N. Wolfe Street, Baltimore, MD 21287
---	--

31. Date filed (Month, Day, Year) SEP 07 2011	32. Registrar's Signature A. Garzon
--	--

Say to Me

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28291  
Reg. No.1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thomas Leo Knott, Jr.</b>				2. Date of Death Month <b>September</b> Day <b>3</b> Year <b>2011</b>	3. Time of Death <b>5:26A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>14104 Shirley Bohn Road</b>		4b. City, Town, or Location of Death <b>Mt. Airy</b>		4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>218-38-1842</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 30, 1936</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b>		10c. City, Town or Location <b>Mt. Airy</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>14104 Shirley Bohn Rd.</b>			10f. Zip Code <b>21771</b>	10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>molder</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>			16b. Kind of Business Industry <b>iron &amp; steel co.</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas Leo Knott, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Rimmick McDonough</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Betty Jean Knott/ wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14104 Shirley Bohn Rd. Mt. Airy, MD 21771</b>		Date <b>9/6/2011</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Resthaven Mem. Gard.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Mem. Gard.</b>		20c. Location - City or Town, State <b>Frederick, MD</b>			
	21. Signature of Funeral Service Licensee <b>Catharine O. Hartzler</b>		22. Name and Address of Facility <b>Hartzler Funeral Home</b> <b>11802 Liberty Rd. Libertytown, MD 21762</b>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Ischemia</b>							Approximate Interval Between Onset and Death <b>hours</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Metastatic lung cancer</b>							
	a. Due to (or as a consequence of): <b>Myocardial Ischemia</b>	b. Due to (or as a consequence of): <b>Metastatic lung cancer</b>	c. Due to (or as a consequence of):	d.				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>				23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cancer cachexia</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D44164</b>		29d. Date signed (Month, Day, Year) <b>9/4/11</b>			
	29b. Signature and title of certifier <b>A.Z. HEGAZI, MD</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.Z. HEGAZI, MD 46371 Drive Frederick MD 21702</b>							
Division of Vital Records, P.O. Box 68760	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Laura J. Parker</b>					

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28292

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle Keller

2. Date of Death

Month Day Year

3. Time of Death

9:20 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

9354 Colonial Mill Drive

4b. City, Town, or Location of Death

Delmar

4c. County of Death

Wicomico

5. Social Security Number

200-30-8601

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

Month Day Year

Feb. 22, 1939

9. Birthplace (State or Foreign Country)

Pennsylvania

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

9354 Colonial Mill Drive

10f. Zip Code

21875

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

home

17. Father's Name (First, Middle, Last)

Joseph Edward Bruhn

18. Mother's Name (First, Middle, Maiden Surname)

Esther Anna Whigam

19a. Informant's Name/Relationship (Type, Print)

Coastal Hospice

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2604 Old Ocean City Road Salisbury, MD 21801

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

Approximate Interval Between Onset and Death

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Lung Cancer

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
1  Yes 2  No

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  HomicideHospital: 1  Inpatient 2  ER/Outpatient 3  D.O.A. Other:

26. Place of Death (Check only one)

1  Nursing Home 5  Residence 6  Other (Specify)

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DAVID COULL, MD COASTAL HOSPICE PO BOX 1733 SALISBURY, MD 21802

29c. License number

D26278

29d. Date signed (Month, Day, Year)

8-23-11

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

Ronald S. Wade

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dvr g919 9-7-11 vt

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28293

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>SEPTEMBER</u> Day <u>1</u> Year <u>2011</u>		3. Time of Death <u>1533</u> M	
<u>DELAREE KIMBLE</u>					
4a. Facility Name (if not institution, give street and number) <u>NORTHWEST HOSPITAL</u>		4b. City, Town, or Location of Death <u>RAWDALYSTOWN</u>		4c. County of Death <u>BALTIMORE</u>	
5. Social Security Number <u>214-40-9204</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs, last birthday) <u>67</u> Yrs.	If Under 1 Year Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
				8. Date of Birth (Month, Day, Year) <u>NOV. 17, 1943</u>	9. Birthplace (State or Foreign Country) <u>MD</u>
Usual Residence of Decedent		10a. State <u>MD</u> 10b. County <u>Baltimore</u> 10c. City, Town or Location <u>Windsor Mill</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <u>2813 Diamond Ridge Rd. Apt.101</u>		10f. Zip Code <u>21244</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <u>5 yrs</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <u>Teacher</u>		16b. Kind of Business Industry <u>Baltimore City Department Education</u>	
17. Father's Name (First, Middle, Last) <u>Alex Lee</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Carrie Webster</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Ashanta Lee (daughter)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2813 Diamond Ridge Rd. Apt.101 21244 Baltimore, Md.</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>King Memorial Pk.</u>		Date <u>Sept. 9, 2011</u>	20c. Location - City or Town, State <u>Balto, Md.</u>
21. Signature of Funeral Service Licensee		22. Name and Address of Facility <u>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. <u>Respiratory Failure</u> Due to (or as a consequence of): <u>Pneumonia</u>					
b. <u>Lymphoma</u> Due to (or as a consequence of): <u>Leukemia</u>					
c. <u>Unknown</u> Due to (or as a consequence of):					
d. <u>Unknown</u> Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <u>Rohit Khatib</u>		29c. License number <u>D0067210</u>		29d. Date signed (Month, Day, Year) <u>9/11/2011</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ROHIT KHTIBAT 801 Tollhouse Ave. Suite B2 Frederick, Md. 21701</u>					
31. Date filed (Month, Day, Year) <u>SEP 07 2011</u>		32. Registrar's Signature <u>Susan S. Patel</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28294

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Simpkin Dealbert Lee</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>2011</b>	3. Time of Death P.M. <b>05:56</b>	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>St. Agnes Hospital</b>		4b. City, Town or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director		5. Social Security Number <b>unk</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months <b>12</b>	If Under 24 Hrs. Days <b>17</b>	8. Date of Birth (Month, Day, Year) <b>12/17/1936</b>	9. Birthplace (State or Foreign Country) <b>N. Carolina</b>
To Be Completed by Funeral Director		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <b>1 X Yes 2 No</b>
		10e. Street and Number <b>5621 Belleville Ave.</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
		11. Marital Status <b>1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Self Employed</b>		16b. Kind of Business Industry <b>Business man</b>		
		17. Father's Name (First, Middle, Last) <b>Edward Lee</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Bryant</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Lena B. Lee (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5621 Belleville Ave., Baltimore, MD 21207</b>				
		20a. Method of Disposition <b>1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>on-site Crematory</b>		Date <b>09/02/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
		21. Signature of Funeral Service Licensee <b>► Q. B. B.</b>		22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave.; Baltimore, MD 21217</b>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Respiratory failure</b>		Approximate Interval Between Onset and Death <b>40 min.</b>		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): <b>Congestive Heart Failure</b>		unknown		
		23d. Due to (or as a consequence of): <b>End-Stage Liver disease</b>				unknown		
		23e. Due to (or as a consequence of): <b>End-Stage Kidney disease</b>				unknown		
		23f. Date of delivery Month <b>Day</b> Year <b>09/02/11</b>						
		23g. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>						
		24a. Was an autopsy performed? <b>1 □ Yes 2 X No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b>				
		25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 X ER/Outpatient 3 □ D.O.A.</b>		Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>		
		27. Manner of Death <b>1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>						
		29b. Signature and title of certifier <b>► Lena J. Fields, DO</b>		29c. License number <b>H72243</b>		29d. Date signed (Month, Day, Year) <b>8/28/11</b>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>St Agnes Hospital, 900 South Caton Ave, Baltimore, MD 21229</b>						
		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Lena J. Fields</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
AMEND ITEM 5, 10a, b, 20a-c, 22 per FH, G919, 9/8/2011, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28295

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

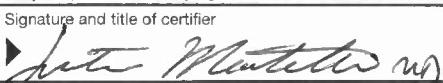
Baltimore, Maryland 21215-0036  
Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 08 Day 25 Year 2011			3. Time of Death 11:30 PM		
Lavelda Mayo							
4a. Facility Name (if not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore			4c. County of Death		
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 20, 1957	9. Birthplace (State or Foreign Country) Florida
Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2327 N. Charles Street			10f. Zip Code 21218			10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business Industry Popeyes healthcare			
17. Father's Name (First, Middle, Last) Leonard Mayo			18. Mother's Name (First, Middle, Maiden Surname) Wilbur Smiley				
19a. Informant's Name/Relationship (Type, Print) Theresa Poke/sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3019 Grayson Street Baltimore, MD 21216				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey		Date 9/7/2011	20c. Location - City or Town, State Woodbine, MD		
21. Signature of Funeral Service Licensee Ronald S. Wade Director		22. Name and Address of Facility Beverly D. Cromartie FTS 2700 Edmondson Ave. Baltimore, MD 21201-21223					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 24 hours	
<p>a. Severe sepsis Due to (or as a consequence of):</p> <p>b. Ischemic cardiomyopathy Due to (or as a consequence of):</p> <p>c. Severe coronary artery disease Due to (or as a consequence of):</p> <p>d. _____</p>						6-10 years 20 years	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number 2438946-011			29d. Date signed (Month, Day, Year) 08/25/11		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital 201 East University Parkway Baltimore, MD 21218							
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature 					

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28296

**1- For State Registrar**

Reg. No.

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1643 hrs
<b>Michael Aaron Miller</b>	September 2, 2011	

**Funeral Director**

4a. Facility Name (if not institution, give street and number) <b>52 E. 26th Street</b>	4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death <b>N/A</b>	
5. Social Security Number <b>220-94-8194</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>32</b> Yrs.	If Under 1 Year Months Days Hours Min.

**May 22, 1979****N/A****Baltimore,  
Maryland**

8. Date of Birth (MM/DD/YYYY) <b>May 22, 1979</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>
--	--

Usual Residence of Decedent

10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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10e. Street and Number <b>52 E. 26th Street</b>	10f. Zip Code <b>21218</b>	10g. Citizen of What Country? <b>United States</b>
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	14. Race - American Indian, Black, White, etc.
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>N/A</b>	16b. Kind of Business/Industry <b>Waiter</b>
--	---	---

17. Father's Name (First, Middle, Last) <b>Raymond Albert Miller</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Mona Lynn Morrow</b>
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19a. Informant's Name/Relationship (Type, Print) <b>(Wife)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Mrs. Franziska (nee Scherzer) Miller 3510 Greenmount Ave. Baltimore, MD. 21218</b>
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel and Cremation Services, Inc.</b>	Date <b>Saturday, Sept. 10, 2011</b>	20c. Location - City or Town, State <b>(Harford County) Forest Hill, Maryland</b>
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair, Sr. OFP</b>	Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215</b>
--	--

22a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
--	--

Immediate Cause (Final disease or condition resulting in death)	a. <b>Heroin Intoxication</b> Due to (or as a consequence of):
---	---

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
--	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g919 9-9-11 sm
--	---

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	---

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>fd 9-2-11</b>	28b. Time of Injury <b>fd 4:38 pm</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Unknown</b>
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found at home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>52 E. 26th St. Baltimore, Md.</b>
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <b>J.M. Titus</b>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 3, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature <b>James A. Gair</b>
---	---

ORIGINAL

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28297

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William H. Murphy	September 5, 2011	5:15P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11 West 20th St. Apt. 12R	Baltimore	N/A

To Be Completed by Funeral Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 10, 1950	9. Birthplace (State or Foreign Country) MD
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
------------------	--------------------	--	--

10e. Street and Number 11 W. 20th St. Apt. 12R	10f. Zip Code 21218	10g. Citizen of What Country? USA
---	------------------------	--------------------------------------

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Tech Support	16b. Kind of Business Industry NASA
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17. Father's Name (First, Middle, Last) Frank N. Murphy Sr.	18. Mother's Name (First, Middle, Maiden Surname) Jennie Eva Smith
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19a. Informant's Name/Relationship (Type, Print) Peggy Womack - Sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4042 Boarman Ave. Baltimore, MD
---	--

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial PK.	Date 9-10-11	20c. Location - City or Town, State Randallstown, MD
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21. Signature of Funeral Service Licensee ► [Signature]	22. Name and Address of Facility Gary P. March F/H 270 Fred Hilton Pass Baltimore, MD 21229
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): massive heart attack	10 year		
b. Due to (or as a consequence of): coronary artery disease	20 year		
c. Due to (or as a consequence of): Diabetes	20 year		
d. Due to (or as a consequence of): hypertension	20 year		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, peripheral vascular diseases	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
---	---	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier ► [Signature]	29c. License number D0056254	29d. Date signed (Month, Day, Year) September 7, 2011
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Nan NI 200 E 33rd st, Union Memorial Hospital Baltimore, MD
--

31. Date filed (Month, Day, Year) SEP 07 2011	32. Registrar's Signature [Signature]
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28298

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

SEPTEMBER 4, 2011 3:20 P.M.

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

CATHERINE MOORE

Division of Vital Records, P.O. Box 68760

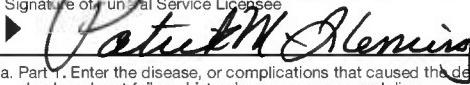
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Catherine T. Moore</b>						2. Date of Death Month 09 Day 04 Year 2011		3. Time of Death 3:20 PM	
<b>Physician/ Medical Examiner</b>		4a. Facility Name (if not institution, give street and number) <b>Stella Maris</b>			4b. City, Town, or Location of Death <b>Timonium</b>			4c. County of Death <b>Baltimore</b>			
<b>Funeral Director</b>		5. Social Security Number <b>214-03-7751</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 94	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug 19 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
										10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>					
		10e. Street and Number <b>509 A Cider Press Court</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>United States</b>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry <b>Baker</b>		16c. Kind of Business Industry <b>Grocery</b>			
		17. Father's Name (First, Middle, Last) <b>John Hook</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bridget Ormand</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Barbara Fleischmann - DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>273 Crandell Road, Severna Park, MD 21146</b>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>		Date <b>09-06-2011</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Cremation Society Of Maryland</b>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death	
		{									
		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____									
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>R149792</b>		29d. Date signed (Month, Day, Year) <b>9/6/2011</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28299

Reg. No.

## 1- For State Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Craig Edward Myers</b>							2. Date of Death Month Day Year <b>September 2, 2011</b>	3. Time of Death 0200 hrs		
	4a. Facility Name (If not institution, give street and number) <b>University Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death			
<b>Funeral Director</b>	5. Social Security Number <b>219-25-6882</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>26 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Days <b> </b>	8. Date of Birth (MM/DD/YYYY) <b>Oct. 23, 1984</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Rocky Ridge</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>14002 B Motters Station Rd.</b>				10f. Zip Code <b>21778</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>				12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) mechanic diesel heavy equipment truck</b>			16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) <b>Ronald E. Myers</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Cindy G. Phipps</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Steven D. Myers/ brother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17212 Mountain View Rd. Emmitsburg, MD 21727</b>						
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chapel Cemetery</b>			Date <b>9/6/2011</b>	20c. Location - City or Town, State <b>nr. Libertytown, MD</b>			
21. Signature of Funeral Service Licensee <b>Catharine O. Hartzler</b>				22. Name and Address of Facility <b>Hartzler Funeral Home 404 S. Main St. Woodboro, MD 21798</b>							
<b>Physician/ Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries with complications</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.									Approximate Interval Between Onset and Death	
	<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>				23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
										24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:</b>									
27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide</b>		28a. Date of Injury <b>Aug 28, 2011</b>		28b. Time of Injury <b>2046 hrs</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Subject assaulted</b>					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) Bar</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6694 Middleburg Road, Keymar, MD</b>							
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) <b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
29b. Signature and title of certifier <b>Theodore M. King, Jr., MD.</b>										29c. License number <b>O.C.M.E. OCME</b>	29d. Date signed (Month, Day, Year) <b>September 2, 2011</b>
30. Name and address of person who completed cause of death (Item 28a) <b>Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>											
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Leanne B. Powell</b>									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 23a per dr., g920, 10/04/2011 dhb  
State Registrar Certificate of Death

Reg. No.

2011 28300

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or if items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Paul, John, Misiak</i>		2. Date of Death Month 09 Day 03 Year 2011		3. Time of Death 11:03 AM		
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>Baltimore VA Medical Center Baltimore</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death -		
		5. Social Security Number <i>558-80-5217</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>May 13, 1949</i>	9. Birthplace (State or Foreign Country) <i>Michigan</i>
		Usual Residence of Decedent 10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Woodstock</i>		
		10e. Street and Number <i>10600 Davis Avenue Apt A-10</i>		10f. Zip Code <i>21163</i>		10g. Citizen of What Country? <i>United States</i>		
		11. Marital Status <i>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</i>	12. Was Decedent Ever in U.S. Armed Forces? <i>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <i>Vietnam</i></i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</i>		14. Race - American Indian, Black, White, etc. <i>Specify: White</i>		
		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Self-Employed</i>		16b. Kind of Business Industry <i>Telecommunications</i>		
		17. Father's Name (First, Middle, Last) <i>Edward Misiak</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Barbara Harbrook</i>				
		19a. Informant's Name/Relationship (Type, Print) <i>Micah P Misiak /Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4 Boulder Court Cockeysville, MD 21030</i>				
		20a. Method of Disposition <i>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>		Date Sep 08, 2011	20c. Location - City or Town, State <i>Beltsville, Maryland</i>	
		21. Signature of Funeral Service Licensee <i>John Doe Ritter MU1443</i>		22. Name and Address of Facility <i>Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286</i>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <i>hypoxic brain injury</i> <b>Esophageal Cancer</b>				
				b. Due to (or as a consequence of):				
				c. Due to (or as a consequence of):				
				d. Due to (or as a consequence of):				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</i>		23c. If yes, outcome of pregnancy <i>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</i>		23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</i>		
						24a. Was an autopsy performed? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>	24b. Were autopsy findings available prior to completion of cause of death? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	
		25. Was case referred to medical examiner? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <i>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</i>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier <i>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>						
		29b. Signature and title of certifier <i>Gluchi Amaram</i>		29c. License number <i>1487949723</i>		29d. Date signed (Month, Day, Year) <i>09/03/2011</i>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gluchi Amaram M.D. 10 North Greene St. Baltimore, MD 21201</i>						
State Registrar		31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Susan L. Powell</i>				

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

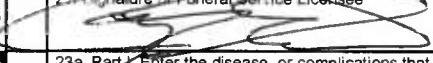
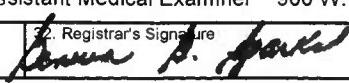
State of Maryland / Department of Health and Mental Hygiene

2011 2830

**Certificate of Death**

Reg. No.

## 1. For State Registrar

Physician/Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Jennifer Mister</b>					2. Date of Death Month Day Year <b>September 2, 2011</b>		3. Time of Death 2250 hrs		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>3543 5th Street</b>			4b. City, Town, or Location of Death <b>Brooklyn</b>			4c. County of Death			
		5. Social Security Number <b>219-96-9860</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>33</b>	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) <b>10/03/1977</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County					10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>3543 5th Street</b>			10f. Zip Code <b>21225</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>disabled</b>			16b. Kind of Business/Industry <b>disabled</b>				
		17. Father's Name (First, Middle, Last) <b>Allen Leroy Mister</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Deborah Marie Burton</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Allen Leroy Mister (Father)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3543 5th Street, Baltimore, Maryland 21225</b>						
Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>			Date <b>09/07/2011</b>	20c. Location - City or Town, State <b>Glen Burnie, Md.</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Joseph M. Eckart 1023 Irwins Choice, Bel Air, Maryland 21014</b>						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Morphine Intoxication</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death				
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g920 10-14-11 sm									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene						
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>fd 9-2-2011</b> 28b. Time of Injury <b>fd 10:55 pm</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b> 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3543 5th St. Brooklyn, Md.</b>			28d. Describe how injury occurred <b>unknown</b>			
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 3, 2011</b>			
		30. Name and address of person who completed cause of death (Item 23a) <b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>									
		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature 						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28302

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter L McJilton</b>							2. Date of Death Month <b>8</b> Day <b>31</b> Year <b>2011</b>	3. Time of Death <b>7:33 P M</b>		
	4a. Facility Name (if not institution, give street and number) <b>University of Maryland Medical Center</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death				
Funeral Director	5. Social Security Number <b>216-20-3459</b>	6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Apr. 18, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <b>1 □ Yes 2 X No</b>		
	10e. Street and Number <b>1833 Prindle Drive</b>			10f. Zip Code <b>21015</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <b>1 □ Never Married 2 X Married</b> 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No</b> If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No</b> Specify:			14. Race - American Indian, Black, White, etc. <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>3</b>		16b. Kind of Business Industry <b>Strike Force Agent</b>			<b>IRS</b>			
	17. Father's Name (First, Middle, Last) <b>Walter LeRoy McJilton Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen (unk) Meyers</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Edith McJilton / Spouse</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1833 Prindle Drive, Bel Air, Maryland 21015</b>							
Physician/ Medical Examiner	20a. Method of Disposition <b>1 X Burial 2 □ Cremation 3 □ Removal from State</b> 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>		Date <b>9-6-11</b>	20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>					
	21. Signature of Funeral Service Licensee <b>Charles A. Engle</b>			22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>							
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary edema</b>								Approximate Interval Between Onset and Death <b>Unknown</b>		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b> a. Due to (or as a consequence of): <b>Ischemic cardiomyopathy</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Oliguric renal failure</b>								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown		
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA		26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		24a. Was an autopsy performed? 1 □ Yes 2 X No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Wood MD</b>			29c. License number <b>17525</b>	29d. Date signed (Month, Day, Year) <b>8 31 2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. Wood MD, University of MD Medical Center, 22 S Greene St, Baltimore MD 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature <b>James J. Parker</b>					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28303

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death M		
Sarah G. Marks		August 31 2011		5:30		
4a. Facility Name (if not institution, give street and number) 8044 Wynbrook Road		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
5. Social Security Number 175-05-0055		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) March 23, 1918	
9. Birthplace (State or Foreign Country) PA						
10a. State MD		10b. County Baltimore	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 8044 Wynbrook Road			10f. Zip Code 21224		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-employed		16b. Kind of Business Industry Beautician		
17. Father's Name (First, Middle, Last) Edgar Louden			18. Mother's Name (First, Middle, Maiden Surname) Nellie S. Hubley			
19a. Informant's Name/Relationship (Type, Print) Betty Sholly/daughter-in-law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8052 Lansdale Road Balto. MD 21224				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		Date 9/6/11	20c. Location - City or Town, State Baltimore MD	
21. Signature of Funeral Service Licensee ▶ Patrick R. Peery		22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of): Aortic Stenosis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier ▶ Jeffrey A. Cool MD		29c. License number D0034650		29d. Date signed (Month, Day, Year) 8/31/11		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medstar 5009 Honeygo center Drive #210 Perry Hall MD 21128 Jeffrey A. Cool						
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Sarah A. Parker				

ORIGINAL

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28304

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
<i>George McGraw</i>		Month	Day	Year	3 PM				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death					
<i>NMS of Hagerstown</i>		<i>Hagerstown</i>		<i>Washington</i>					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth		9. Birthplace/State or Foreign Country			
<i>260-52-4400</i>		<input checked="" type="checkbox"/> M	73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	July 1, 1938	South Carolina		
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits			
MD	Washington	<i>Hagerstown</i>				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?					
<i>1203 Frederick Street #3</i>		21740		USA					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry unk					
Elementary/Secondary (0-12) <i>12</i>	College (1-4 or 5+) <i>5</i>	<i>land surveyor</i>							
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
<i>Bernie Marvin McGraw</i>				<i>Georgiana Richardson</i>					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
<i>Daniel McGraw/son</i>		<i>3713 Quincy Street Brentwood, MD 20722</i>							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)									
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>		22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Bladder Cancer with metastasis</i>						Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. Date signed (Month, Day, Year)	
29b. Signature and title of certifier <i>Stephanie Comer CRNP</i>		29c. License number <i>R125748</i>		29d. Date signed (Month, Day, Year) <i>8/26/2011</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
<i>Stephanie Comer - Concordia CRNP 14014 Marsh Pike Hagerstown MD 21742</i>									
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Suzanne B. Parker</i>							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28305

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
 Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Baltimore, Maryland 21215-0036  
 8-25-11 2:00 PM
 Novena McCollins  
 Division of Vital Records, P.O. Box 68760  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 8 Day 25 Year 11		3. Time of Death 2:00 PM
Novenia Mc Collins				
4a. Facility Name (if not institution, give street and number) Joseph Richey Hospice		4b. City, Town, or Location of Death Baltimore		4c. County of Death
5. Social Security Number 217-17-5697		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	8. Date of Birth (Month, Day, Year) Nov 20, 1938
9. Birthplace (State or Foreign Country) unk				
10a. State MD		10b. County		10c. City, Town or Location Baltimore
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 302 Melvin Avenue		10f. Zip Code 21228		10g. Citizen of What Country? USA
11. Marital Status unk		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: black	
14. Race - American Indian, Black, White, etc. Specify: black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business Industry unk
17. Father's Name (First, Middle, Last) Joseph Richey Hospice		18. Mother's Name (First, Middle, Maiden Surname) unk		unk
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State Date
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death End stage lung disease		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of): COPD				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Dr. Karen Cosans-Brown		29c. License number H0064267		29d. Date signed (Month, Day, Year) 8-26-11
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Karen Cosans-Brown 827 Linden Av Balt MD 21201				
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Laura S. Park		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28306

1 For  
State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie MacNeal

2. Date of Death  
Month August Day 20 Year 2011

3. Time of Death  
7:45 PM

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-18-4307

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb 16, 1922

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1  Yes 2  No X

10e. Street and Number

5404 Ready Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

unk

1  Never Married 2  Married

3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Seconday (0-12)  
unk

College (1-4 or 5+)  
unk

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business Industry

unk

17. Father's Name (First, Middle, Last)

Maynard Kirkland

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Streb

19a. Informant's Name/Relationship (Type, Print)

James MacNeal/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5404 Ready Avenue Baltimore, MD 21212

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State

4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

62 Name and Address of Facility

State Anatomy Board 655 W, Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Days

medical complication of a fall

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approved  
R. S. Wade, Director  
State Anatomy Board  
Baltimore, MD 21201

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy

4  Pregnant at time of death 5  Other (Specify)

9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

Hospice

27. Manner of Death

1  Natural

5  Pending Investigation

2  Accident

6  Could not be determined

3  Suicide

7  Homicide

28a. Date of injury (Month, Day, Year)

8/15/2011

28b. Time of injury

Approx 6 PM

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

Fell at the top of her stairs, laid on the floor 48 hours until found by

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5404 Ready Avenue, Baltimore, MD 21212

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley G BMC 6701 N. Charles St. Baltimore, MD 21205

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

Anna B. Parker

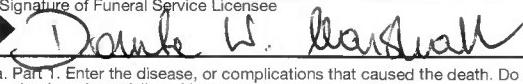
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28307

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Linda Diane Mitchell</b>							2. Date of Death Month August Day 31 Year 2011	3. Time of Death 7:35 p M			
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>					
Funeral Director	5. Social Security Number <b>216-54-0406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 7, 1949</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Abingdon</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>622 Nanticoke Court</b>				10f. Zip Code <b>21009</b>			10g. Citizen of What Country? <b>U.S.A</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2</b>			16b. Kind of Business Industry <b>Federal Employee</b>						
17. Father's Name (First, Middle, Last) <b>William Mitchell</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Wolfe</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Yolanda Tawney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>622 Nanticoke ct. Abingdon, MD 21009</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CCI Chesapeake</b>			Date <b>9/2/2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Maryland Cremation Services P.O. Box 1413 Baltimore, MD 21203</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ecophageal Cancer</b>									Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): <b>Ecophageal Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Kidney Transplant Breast Cancer</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier 		M.D.		29c. License number <b>D0071287</b>		29d. Date signed (Month, Day, Year) <b>9-1-11</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>												
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death2011 28308  
Reg. No.1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

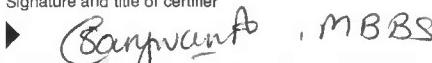
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
JAMES MURDAUGH		AUG 29 2011				1204 PM		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
Johns Hopkins Bayview Medical Center		Baltimore						
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 11, 1949	9. Birthplace (State or Foreign Country) North Carolina	
214-54-4872								
Usual Residence of Decedent		10c. City, Town or Location					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland	10b. County Baltimore	Dundalk						
10e. Street and Number 8014 Bank Street			10f. Zip-Code 21224			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years		16b. Kind of Business/Industry Sergeant First Class			16c. Kind of Business/Industry United States Army	
17. Father's Name (First, Middle, Last) Franklin Murdaugh		18. Mother's Name (First, Middle, Maiden Surname) Lena Batts						
19a. Informant's Name/Relationship (Type, Print) Barbara Murdaugh wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8014 Bank Street, Baltimore, Maryland 21224						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date September 3, 2011		20c. Location - City or Town, State Dundalk, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222						
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					Approximate Interval Between Onset and Death	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number RES-066			29d. Date signed (Month, Day, Year) AUG 29, 2011			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANJIVANI KOLGE							4940 Eastern Avenue, Baltimore, MD, 21224	
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature 						

State  
Registrar

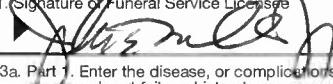
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28309  
Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death 9:30 a <sup>M</sup>
	Robert Martin		September 2, 2011	Dundalk		
<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>7000 Railway</b>			4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>
	5. Social Security Number <b>213-34-6312</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>73 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>October 24, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <b>1 □ Yes 2 X No</b>
10e. Street and Number <b>7000 Railway Avenue</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 □ No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 6 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business Industry <b>Machinery</b>		
17. Father's Name (First, Middle, Last) <b>Leslie Lee Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Pierczshalski</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Bettie Jean Martin wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7000 Railway Avenue, Dundlak, Maryland 21222</b>			
20a. Method of Disposition <b>1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Date <b>September 6, 2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of): <b>PULMONARY FIBROSIS</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 □ No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DIABETES</b> <b>HYPERTENSION</b>						
23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>						
<p>24a. Was an autopsy performed? <b>1 □ Yes 2 X No</b></p> <p>24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b></p>						
25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 X Residence 6 □ Other (Specify)</b>				
27. Manner of Death <b>1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>038635-SA</b>		29d. Date signed (Month, Day, Year) <b>9/2/2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KISHORE JUDYAVAR 9600 NORTH PT. RD., FORT HOWARD, MD 21032</b>						
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 				

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68700**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State  
Registrar**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28310  
Reg. No.

1- For State Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

*Massoni, Susan*  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760  
9/2/11 8:55 AM

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute
<i>Susan Massoni</i>		9 2 11		8:55 AM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Oak Crest Village		Perry Hall		Baltimore
5. Social Security Number <i>212-36-9603</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>70</i> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>February 28, 1941</i>
Usual Residence of Decedent Maryland Baltimore		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
10a. State Maryland		10b. County Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10c. City, Town or Location Parkville				
10e. Street and Number 1918 Wildwood Avenue		10f. Zip Code 21234		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 years</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>Cashier</i>		16b. Kind of Business Industry <i>Acme Food Store</i>
17. Father's Name (First, Middle, Last) <i>Chester L. Noland</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Bertha Krysiak</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Leslie DiDonato</i> sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6735 Pine Avenue, Dundalk, Maryland 21222</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley</i>	20c. Date <i>September 6, 2011</i>	20c. Location - City or Town, State <i>Timonium, Maryland</i>
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <i>aspiration pneumonia</i>				
b. Due to (or as a consequence of): <i>dysphagia</i>				
c. Due to (or as a consequence of): <i>Alzheimer's disease</i>				
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		
		29c. License number <i>J 1442</i>		
		29d. Date signed (Month, Day, Year) <i>9/2/11</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bruce Bremner MD 8800 Wilshire Blvd Parkville Md 21234</i>				
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 17 per fh g919 9-7-11 vt

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend Item 25 per me, g918, 08/31/2011dhb Certificate of Death

Reg. No. 2011 28311

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Ann McGhee</b>							2. Date of Death Month <b>August</b> Day <b>4</b> Year <b>2011</b>	3. Time of Death <b>20:21 M</b>			
	4a. Facility Name (if not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>MD</b>					
Funeral Director	5. Social Security Number <b>217-56-5470</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>April 4, 1951</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>7212 McClean Blvd.</b>			10f. Zip Code <b>21234</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates. <b>12th</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>certified Nursing Asst.</b>			16b. Kind of Business Industry <b>Hospital</b>					
	17. Father's Name (First, Middle, Last) <b>Oscar Wright Andrew Downey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Geraldine Murray</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Tamatha Martin (daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5302 Marion St, North Little Rock, Arkansas 72118</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>King Memorial Pk</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Pk</b>			Date <b>Aug.10, 2011</b>	20c. Location - City or Town, State <b>Balto, Md.</b>				
	21. Signature of Funeral Service Licensee			Signature Address of Facility <b>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</b>								
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Gastrointestinal bleeding</b>								Approximate Interval Between Onset and Death			
	a. Due to (or as a consequence of): <b>Gastrointestinal bleeding</b>											
	b. Due to (or as a consequence of):											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. License number <b>AT2438946-B5</b>		29d. Date signed (Month, Day, Year) <b>8/15/2011</b>	
	29b. Signature and title of certifier <b>► Harjit Chahal MD</b>											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARJIT CHAHAL, 2015 UNIVERSITY PKWY, BALTIMORE, MD</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 31 2011</b>			32. Registrar's Signature <b>Laura J. Foster</b>								

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28312

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Marlene Beverly Miller

2. Date of Death

Month August

Day 28

Year 2011

3. Time of Death

0824 hrs

**Funeral  
Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

4a. Facility Name (if not institution, give street and number) 7 Strawhat Road Apt. 2C	4b. City, Town, or Location of Death Owings Mills	4c. County of Death Baltimore County						
5. Social Security Number 506-38-7385	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24Hrs. Days	8. Date of Birth (MM/DD/YYYY) 03/17/1934	9. Birthplace (State or Foreign Country) Iowa		
10a. State MD						10b. County Baltimore Co.	10c. City, Town or Location Owings Mills	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 17 Strawhat Rd.			10f. Zip Code 21117			10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black			14. Race - American Indian, Black, White, etc.			
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	If Yes, Give Year or Dates:							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 years			16b. Kind of Business/Industry NIH- Nat'l Institute of Health			
17. Father's Name (First, Middle, Last) Roscoe Miller			18. Mother's Name (First, Middle, Maiden Surname) Hazel Tramble					
19a. Informant's Name/Relationship (Type, Print) V.J. Miller Tramble (child)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 24604 Baltimore, MD 21214						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) on-site Crematory			Date 08/30/11	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217						

**Baltimore, MD 21215-0036****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician  
/Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. Smoke Inhalation Due to (or as a consequence of):			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: Aug 28, 2011	28b. Time of Injury FOUND: 0820 hrs
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject victim of dwelling fire
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Multi-Family Apt.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7 Strawhat Road Apt. 2C, Owings Mills, MD
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 29, 2011
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature 	

(2)

(2)

(2)

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28313

For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <i>Robert Meo</i>		2. Date of Death Month 8 Day 18 Year 11		3. Time of Death 3:32 PM
4a. Facility Name (if not institution, give street and number) <i>Genesis Heritage</i>		4b. City, Town, or Location of Death <i>Dundalk, MD</i>		4c. County of Death <i>Baltimore</i>
5. Social Security Number <i>215-30-8793</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 15, 1934
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>
10e. Street and Number <i>22 S. Decker Avenue</i>		10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <i>white</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>0</i>		16b. Kind of Business Industry <i>unk</i>
17. Father's Name (First, Middle, Last) <i>Charles Peter Meo</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Ruth Kirby</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Michael Caschetta/nephew</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2801 Kings Gift Drive Ellicott City, MD 21042</i>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>		22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>pneumonia</i> Due to (or as a consequence of):</p> <p>b. <i>Congestive Heart Failure</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Renal Failure</i>				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>R122580</i>		
29b. Signature and title of certifier <i>LIBBY SHADIS, CRNP</i>		29d. Date signed (Month, Day, Year) <i>8/18/11</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LIBBY SHADIS CRNP 2 Marketplace Dundalk, MD 21222</i>				
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Susan A. Spakler</i>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28314

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>SYLVIA NALL</b>		2. Date of Death Month <b>09</b> Day <b>03</b> Year <b>2011</b>		3. Time of Death <b>1215 PM</b>
4a. Facility Name (if not institution, give street and number) <b>Season Hospice at Northwest</b>		4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>214-38-4259</b>		6. Sex <b>1 M 2 XF</b>	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months      Days      Hours      Min.
Usual Residence of Decedent <b>Maryland Baltimore</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>
10c. City, Town or Location <b>Gwynn Oak</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2145 Lorraine Avenue</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Health Care Aide</b>		16b. Kind of Business/Industry <b>Health Care</b>
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown Kennecker</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sharon West - FRIEND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2145 Lorraine Avenue, Gwynn Oak, MD 21207</b>		
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>	Date <b>09-06-2011</b>	20c. Location - City or Town, State <b>Baltimore Maryland</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Cremation Society Of Maryland 299 Frederick Road, Baltimore, MD 21228 INC</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Advanced Dementia</b>		
a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23d. Date of delivery Month      Day      Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE INPATIENT</b>		
27. Manner of Death <b>1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D67220</b>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>09/03/2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sylvia Nall, MD, 2835 Lorraine Ave. #203, Baltimore, MD.</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 		

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 201128315

<b>Baltimore, Maryland 21215-0036</b> <small>Division of Vital Records, P.O. Box 68760      To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.      To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.</small>		<p><b>Physician/ Medical Examiner</b></p> <p><b>Richard Vincent NEWMAN</b></p> <p>1. Decedent's Name (First, Middle, Last)</p> <p>4a. Facility Name (If not institution, give street and number) <b>Lock Haven Community Living Center</b></p> <p>2. Date of Death Month <b>9</b> Day <b>4</b> Year <b>2011</b></p> <p>3. Time of Death <b>10:07 AM</b></p> <p>4b. City, Town, or Location of Death <b>Baltimore</b></p> <p>4c. County of Death <b>-</b></p> <p><b>Funeral Director</b></p> <p>5. Social Security Number <b>218-18-4388</b></p> <p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) <b>86</b> Yrs.</p> <p>If Under 1 Year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b></p> <p>8. Date of Birth (Month, Day, Year) <b>Feb 18, 1925</b></p> <p>9. Birthplace (State or Foreign Country) <b>Maryland</b></p> <p>Usual Residence of Decedent</p> <p>10a. State <b>MD</b></p> <p>10b. County <b>Baltimore</b></p> <p>10c. City, Town or Location <b>Gwynn Oak</b></p> <p>10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>10e. Street and Number <b>1921 Hillcrest Road</b></p> <p>10f. Zip Code <b>21207</b></p> <p>10g. Citizen of What Country? <b>United States</b></p> <p>To Be Completed by Funeral Director</p> <p>11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <b>WWII</b></p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Bi-Racial</b></p> <p>14. Race - American Indian, Black, White, etc. Specify: <b>Bi-Racial</b></p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b></b></p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chauffeur</b></p> <p>16b. Kind of Business Industry <b>Transport</b></p> <p>17. Father's Name (First, Middle, Last) <b>unk unk</b></p> <p>18. Mother's Name (First, Middle, Maiden Surname) <b>Bette Howe</b></p> <p>19a. Informant's Name/Relationship (Type, Print) <b>Ivy Sweetwine /Daughter</b></p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1921 Hillcrest Road Gwynn Oak, MD 21207</b></p> <p>20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Chesapeake Crematory</b></p> <p>Date <b>Sep 08, 2011</b></p> <p>20c. Location - City or Town, State <b>Beltsville, Maryland</b></p> <p>21. Signature of Funeral Service Licensee <b>M01443</b></p> <p>► <b>Stephanie Bittner</b></p> <p>22. Name of Cremation and Funeral Alternatives <b>Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286</b></p> <p>To Be Completed by Physician/Medical Examiner</p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive Heart Failure</b></p> <p>Approximate Interval Between Onset and Death</p> <p>23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p> <p>27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</p> <p>28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. Signature and title of certifier <b>John R. Roy</b></p> <p>29c. License number <b>D57239</b></p> <p>29d. Date signed (Month, Day, Year) <b>9/4/2011</b></p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Suresh Sharlegya 3909 Lock Haven Boulevard, Baltimore 21218</b></p> <p>31. Date filed (Month, Day, Year) <b>SEP 07 2011</b></p> <p>32. Registrar Signature <b>Henry J. Jones</b></p> <p><b>State Registrar</b></p>						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 6 per FH, G922, 12/5/2011, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28316

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<i>Raymond Norris</i>		Month <i>August</i> Day <i>24</i> Year <i>2011</i>		9:10 A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>The Johns Hopkins Hospital</i>		<i>Baltimore City</i>		N/A
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth
217-34-7071		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	72 Yrs.	Month <i>NOV.</i> Day <i>23</i> Year <i>1938</i>
If Under 1 Year Months <i></i> Days <i></i>		If Under 24 Hrs Hours <i></i> Min. <i></i>		9. Birthplace (State or Foreign Country)
				Maryland
10a. State <i>MD</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>	
10e. Street and Number <i>512 Sheridan Avenue</i>		10f. Zip Code <i>21212</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th Grade</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry <i>Truck Driver</i>
17. Father's Name (First, Middle, Last) <i>Harry Norris</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Bess Whye</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Raymond Norris, Jr. - Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2301 Westfield Avenue Baltimore, Maryland 21214</i>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Luke's U.M. Ch. Cm.</i>		Date <i>9/3/2011</i>
21. Signature of Funeral Service Licensee <i>Chatman-Harris Funeral Home</i>		22. Name and Address of Facility <i>5240 Reisterstown Road Baltimore, MD. 21215</i>		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. <i>Sepsis</i> Due to (or as a consequence of):</p> <p>b. <i>Lung cancer</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>			
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Brian M. Thomas MD</i>	
		29c. License number <i>RES-800</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Brian M. Thomas</i>		29d. Date signed (Month, Day, Year) <i>August 24, 2011</i>	
31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>Leanne S. Parker</i>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28317

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<b>Margaret H. Neal</b>		Month <b>9</b>	Day <b>1</b>	Year <b>2011</b>
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<b>Franklin Square Hospital</b>		<b>Rosedale</b>		<b>Baltimore</b>
5. Social Security Number		6. Sex	7. Age (in yrs. last birthday)	8. Date of Birth (Month, Day, Year)
<b>294-24-5872</b>		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	85 Yrs.	Months <b>July</b> Days <b>29</b> Hours <b>1926</b> Min.
9. Birthplace (State or Foreign Country)		10d. Inside City Limits		
<b>Ohio</b>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Middle River</b>	
10e. Street and Number <b>3525 Buckboard Lane</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>Elementary/Seconday (0-12) 12th</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business Industry <b>New Eastern Cab</b>
17. Father's Name (First, Middle, Last) <b>Michael F. Haney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Johnston</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Penelope S. Neal /daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3525 Buckboard Lane Baltimore MD 21220</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Patricia R. Hempe</b>		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Balto.National</b>		Date <b>9/7/11</b>
21. Signatures of Funeral Service Licensee		22. Name and Address of Facility <b>300 Mace Ave. Balto. MD Connally Funeral Home of Essex 21221</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Metastatic Adenocarcinoma</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Patricia R. Hempe</b>		
29c. License number <b>H69248</b>		29d. Date signed (Month, Day, Year) <b>9/1/11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Carrie Hempe 9000 Franklin Square Drive Baltimore, MD 21237</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		
32. Registrar's Signature <b>Laura J. Parker</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28318

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIVIAN NANCE</b>				2. Date of Death Month <b>08</b> Day <b>23</b> Year <b>2011</b>	3. Time of Death M													
	4a. Facility Name (if not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>												
Funeral Director	5. Social Security Number <b>546-20-0778</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Sept 24, 1917</b>	9. Birthplace (State or Foreign Country) <b>Canada</b>												
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Prince George's</b>				10c. City, Town or Location <b>Bowie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X											
To Be Completed by Funeral Director	10e. Street and Number <b>3850 Enfield Chase Court #331</b>			10f. Zip Code <b>20716</b>			10g. Citizen of What Country? <b>USA</b>												
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>1</b> <b>legislative consultant</b>			16b. Kind of Business Industry <b>State of California</b>													
	17. Father's Name (First, Middle, Last) <b>Ira James Day</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margarette G. Wallace</b>														
	19a. Informant's Name/Relationship (Type, Print) <b>Claudia Kannon/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>401 Canaan Street Upper Marlboro, MD 20774</b>															
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State													
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>														
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																		
	<table border="1"> <tr> <td>a.</td> <td>Renal failure, acute on chronic</td> <td>Approximate Interval Between Onset and Death <b>months</b></td> </tr> <tr> <td>b.</td> <td>HTN</td> <td>year</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>							a.	Renal failure, acute on chronic	Approximate Interval Between Onset and Death <b>months</b>	b.	HTN	year	c.			d.		
a.	Renal failure, acute on chronic	Approximate Interval Between Onset and Death <b>months</b>																	
b.	HTN	year																	
c.																			
d.																			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year													
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEPSIS</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
					<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred													
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)													
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
	29b. Signature and title of certifier <b>Michael J. LaPenta</b>			29c. License number <b>021438</b>			29d. Date signed (Month, Day, Year) <b>August 24 2011</b>												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. LAPENTA 445 DEFENSE Hwy Annapolis MD 21401</b>																		
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Seana S. Parker</b>																

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28319

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Frances E. Parks</b>			2. Date of Death Month <b>September</b> Day <b>2</b> , Year <b>2011</b>	3. Time of Death <b>1:55p M</b>
4a. Facility Name (if not institution, give street and number) <b>91 Willow Spring Road</b>			4b. City, Town, or Location of Death <b>Dundalk</b>	
4c. County of Death <b>Baltimore</b>				
5. Social Security Number <b>216-50-2651</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>63 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours Min.
			<b>8. Date of Birth (Month, Day, Year) June 15, 1948</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
10e. Street and Number <b>91 Willow Springs Road</b>			10f. Zip Code <b>21222</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <i>White</i>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12 years</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>	16b. Kind of Business Industry <b>State of Maryland</b>		
17. Father's Name (First, Middle, Last) <b>John W. Smith Jr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Joann Lee</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Oscar Parks</b> Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6716 Ridge Road, Rosedale, Maryland 21237</b>		
20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>	Date <b>September 8, 2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21a. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pancreatic Cancer</b>				
Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): <b>Pancreatic Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b> 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>SP Gastric Bypass</b> <b>Osteoporosis</b>				
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>				
23f. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD 21222</b>

29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>	29c. License number <b>DOO 46595</b>			29d. Date signed (Month, Day, Year) <b>9/3/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shelia Hongi 910 Phil. Rd Suite 110 Baltimore MD 21237</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #6 Per FH G919 9/13/2011 Jh

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28320

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM PM	
<b>Carroll Thomas Pinder</b>		<b>August 29, 2011</b>		<b>548 p M</b>	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<b>Maryland General Hospital</b>		<b>Baltimore City</b>		<b>N/A</b>	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> XX	7. Age (in yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year 12/17/1951
<b>212-56-8076</b>					
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>3511 Woodbrook Ave.</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>			16b. Kind of Business Industry <b>Self Employed</b>
17. Father's Name (First, Middle, Last) <b>John J. Thomas</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Inez Wilson</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Pinder(brother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3511 Woodbrook Ave., Baltimore, MD 21217</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>09/09/11</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. <b>Pulmonary Edema</b> Due to (or as a consequence of):</p> <p>b. <b>Non-Compliance with Hemodialysis</b> Due to (or as a consequence of):</p> <p>c. <b>Health Care Associated Pneumonia</b> Due to (or as a consequence of):</p> <p>d. _____</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  <b>J. Lee M.D.</b>			29c. License number <b>89699</b>		29d. Date signed (Month, Day, Year) <b>8/29/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Lee, M.D. @ Maryland General Hospital</b>					
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28321

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Ralph Arnfinn Quisgard, Jr.</b>		2. Date of Death Month <b>September</b> Day <b>04</b> , Year <b>2011</b>		3. Time of Death <b>7:40 P.M.</b>
4a. Facility Name (if not institution, give street and number) <b>Stella Maris</b>		4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore County</b>
5. Social Security Number <b>215-22-4661</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months      Days      Hours      Min. 8. Date of Birth (Month, Day, Year) <b>July 25, 1928</b>
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Lutherville</b>
10e. Street and Number <b>8634 Chelsea Bridge Way</b>		10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <b>Navy Peacetime</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Public Defender</b>		16b. Kind of Business Industry <b>State of Maryland</b>
17. Father's Name (First, Middle, Last) <b>Ralph Arnfinn Quisgard, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Zelda Oline Graves</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Joan (nee Purkins) Quisgard</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8634 Chelsea Bridge Way Lutherville, MD. 21093</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Evans Funeral Chapel and Cremation Services, Inc.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wednesday, Sept. 07, 2011</b>		20c. Location - City or Town, State <b>(Harford County) Forest Hill, Maryland</b>
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair, Sr. OSP</b> <b>Lic. #M100677</b>		22. Name and Address of Facility <b>Peaceful Alternatives Funeral and CremationCenter, P.A.</b> <b>2325 York Road Timonium, Maryland 21093-226</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <b>Advanced Dementia</b> Due to (or as a consequence of): <b>years</b></p> <p>b. _____ Due to (or as a consequence of): _____</p> <p>c. _____ Due to (or as a consequence of): _____</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) g <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DS 2740</b>		
29b. Signature and title of certifier <b>Ernestine Wright, M.D.</b>		29d. Date signed (Month, Day, Year) <b>September 6th, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Suzanne J. Parker</b>		

State  
Registrar

7:40 P.M.  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28322

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 10:30A M
Vernard Rustad		Sept. 03, 2011		
4a. Facility Name (if not institution, give street and number) <b>Blue Point Nursing Home</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death NA
5. Social Security Number <b>373-22-6597</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month Day, Year) <b>08-16-26</b>
10a. State <b>MD</b>		10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number <b>2525 W. Belvedere Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Caucasian</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>unk.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk.</b>		16b. Kind of Business Industry <b>unk.</b>
17. Father's Name (First, Middle, Last) <b>unk.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unk.</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Freda Jones-Guardian</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>201 E. Baltimore Street 15th Fl. Baltimore MD.</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Mt. Zion Cem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cem.</b>		Date <b>09-07-11</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Wylie Funeral Home P.A.</b> <b>638 N. Gilmor Street Baltimore, MD 21217</b>		20c. Location - City or Town, State <b>Lansdowne, MD</b>
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Atherosclerotic Heart Disease</i>		Approximate Interval Between Onset and Death <b>5 years</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{ a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>End Stage Renal Disease</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0043375</b>		29d. Date signed (Month, Day, Year) <b>9/5/2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2835 South Ave Suite 203 Baltimore, MD 21209</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>Leanne J. Parker</i>

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28323

1 - For State Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Holly Ann Rader</b>			2. Date of Death Month Sept. Day 01, Year 2011	3. Time of Death 4:22 P.M.
4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice</b>			4b. City, Town, or Location of Death <b>Towson</b>	
5. Social Security Number <b>215-42-0410</b>			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.
8. Date of Birth (Month, Day, Year) <b>Aug. 03, 1943</b>		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>
10a. State <b>Maryland</b>			10b. County <b>Baltimore County</b>	10c. City, Town or Location <b>Timonium</b>
10e. Street and Number <b>115 Northwood Drive</b>			10f. Zip Code <b>21093</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Manager</b>	
16b. Kind of Business Industry <b>Dental Office</b>				
17. Father's Name (First, Middle, Last) <b>Thomas William Willetts, D.D.S.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Katherine Hoover</b>	
19a. Informant's Name/Relationship (Type, Print) <b>(Husband)</b> <b>Mr. Richard Andrew Rader</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Northwood Drive Timonium, Maryland 21093</b>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Evans Funeral Chapel and Cremation Services, Inc.</b>	Date <b>Saturday, Sept. 03, 2011</b>
20c. Location - City or Town, State <b>(Harford County) Forest Hill, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair, Sr. CFSP</b>			22. Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A.</b> <b>2325 York Road Timonium, Maryland 21093-2215</b>	
22. Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A.</b> <b>2325 York Road Timonium, Maryland 21093-2215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): <b>Complications of Sepsis</b>				
b. Due to (or as a consequence of): <b>Bacteremia</b>				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Endometrial Cancer</b>			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Endometrial Cancer</b>			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury
			28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>M. J.</b>			29c. License number <b>00071287</b>	29d. Date signed (Month, Day, Year) <b>9-2-11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>			31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	
			32. Registrar's Signature <b>James A. Parker</b>	

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28324

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mercedes Vivian Rankin</b>					2. Date of Death Month September Day 4, Year 2011	3. Time of Death 2:30 P M	
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-34-3960</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>10/04/1933</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent			Min.				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County	10c. City, Town or Location <b>Baltimore City</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>301 McMechen Street, Apt. 922</b>		10f. Zip Code <b>21217</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2</b> <b>Police Officer</b>			16b. Kind of Business/Industry <b>Law Enforcement</b>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Calvin Douglass</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mercedes Hayley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Bryan Rawlings / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11317 Kencrest Drive, Mitchellville, MD 20721</b>					
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomy Gifts Registry</b>		Date <b>09/04/2011</b>	20c. Location - City or Town, State <b>Hanover, Maryland</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Anatomy Gifts Registry</b> <b>7522 Connelley Dr., Ste. P, Hanover, MD 21076</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Urothelial carcinoma/Bladder Cancer</b>								
Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lung Cancer</b>								
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>M. J.</b>						
		29c. License number <b>D0071287</b>			29d. Date signed (Month, Day, Year) <b>9-5-11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28325

1 - For State Registrar

Physician /Medical Examiner

		1. Decedent's Name (First, Middle, Last) <b>Roland Darius Ross</b>				2. Date of Death Month Day Year <b>August 25 2011</b>		3. Time of Death <b>7:30 AM</b>		
		4a. Facility Name (If not institution, give street and number) <b>7121 John Pickett Rd.</b>				4b. City, Town, or Location of Death <b>Woodbine</b>		4c. County of Death <b>Carroll</b>		
Funeral Director		5. Social Security Number <b>218-52-1630</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>64 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug 18, 1947</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b>				10b. County <b>Carroll</b>			10c. City, Town or Location <b>Woodbine</b>	10d. Inside City Limits <b>1 Yes 2 No X</b>
		10e. Street and Number <b>7121 John Pickett Road</b>				10f. Zip Code <b>21797</b>			10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>		unk			16b. Kind of Business/Industry <b>telephone company</b>	
		17. Father's Name (First, Middle, Last) <b>Charles Joseph Ross</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Velma Josephine Brown</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Brad Ross / son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7121 John Pickett Road Woodbine, MD 21797</b>					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
		<p>a. Due to (or as a consequence of): <b>Alcoholic Cirrhosis of liver</b></p> <p>b. Due to (or as a consequence of): <b>Ascites</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Swarna Tamanna DO 708C Lisbon Center Dr, Woodbine</b>		29c. License number <b>MD H 0062176</b>			29d. Date signed (Month, Day, Year) <b>8/26/11</b>			
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 			33. Date issued (Month, Day, Year) <b>MD 2,797</b>			

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

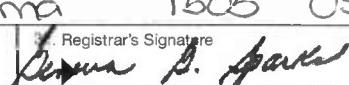
Amend Items 24a, 25 per me g919, 09/07/2011dhb

Certificate of Death

Reg. No.

2011 28326

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian Rosenthal</b>							2. Date of Death Month August 26 Day 2011 Year	3. Time of Death 6:55p M		
	4a. Facility Name (if not institution, give street and number) <b>4223 Silver Spring Road</b>			4b. City, Town, or Location of Death <b>Baltimore County</b>			4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>217 16 4574</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 17 1924</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore County</b>	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number <b>4223 Silver Spring Road</b>			10f. Zip Code <b>21128</b>			10g. Citizen of What Country? <b>USA</b>				
Physician/ Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business Industry <b>Housekeeping Own Home</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Joseph Michno</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Anne Wojciechowski</b>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Camellia L. Rosenthal (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4223 Silver Spring Road Baltimore, Maryland 21128</b>							
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem.</b>		Date <b>Sept. 1 2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service licensee 			22. Name and Address of Facility <b>Lassan Funeral Home Inc</b> <b>7401 Belair Road Baltimore, Maryland 21236</b>							
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Renal Failure</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d. Diabetes Mellitus</b>								Approximate Interval Between Onset and Death <b>10 days</b>		
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 			29c. License number <b>D40048</b>			29d. Date signed (Month, Day, Year) <b>8-29-11</b>				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Boersma 7505 Osler Dr Towson MD 21204</b>										
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>			32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28327

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

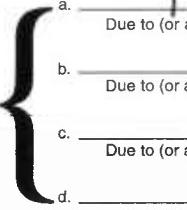
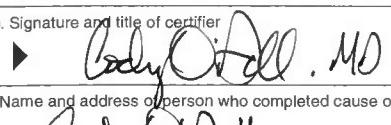
Physician  
/Medical  
Examiner

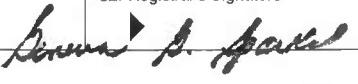
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)			SoKol		2. Date of Death Month Day Year	3. Time of Death Hour:Minute AM/PM
Mary Ellen			Baltimore City		August 29 2011 26:40 PM	
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
The Johns Hopkins Hospital			Baltimore City		N/A	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
048-34-0931		67 Yrs.		Apr 3, 1944	Connecticut	
Usual Residence of Decedent			10c. City, Town or Location			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland	Anne Arundel		Annapolis			
10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?	
222 Severn Avenue			21403		USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner		16b. Kind of Business/Industry Admiral of the Bay		
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)			
William Almond King			Marjorie Grace Doyle			
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Richard A. Sokol, Sr. (Husband)			222 Severn Avenue, Annapolis, Maryland 21403			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
		Atlantic Crematory, LLC		9/3/2011	Glen Burnie, Maryland	
21. Signature of Funeral Service Licensee			22. Name and Address of Facility			
			McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
<p> a. Due to (or as a consequence of): Sepsis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Location (Street and Number or Rural Route Number, City or Town, State)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29c. License number Res-000		29d. Date signed (Month, Day, Year) August 29, 2011

31. Date filed (Month, Day, Year)	32. Registrar's Signature
SEP 07 2011	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

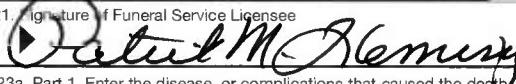
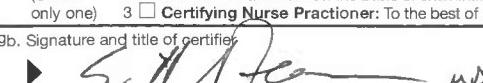
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28328

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Marie G. Sima</b>		2. Date of Death Month 09 Day 03 Year 2011		3. Time of Death 8:35 AM
4a. Facility Name (if not institution, give street and number) <b>Rock Spring Village Assisted Living</b>		4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>215-14-4386</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	8. Date of Birth (Month, Day, Year) <b>02 26 1922</b>
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Harford</b>	10c. City, Town or Location <b>Joppa</b>	
10e. Street and Number <b>2402 Bluefield Circle</b>		10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: /	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>	16b. Kind of Business Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Caleb Griffin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Eierhardt</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Gordon Sima - SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2402 Bluefield Circle, Joppa, Maryland 21085</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>	Date <b>09-06-2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Cremation Society Of Maryland INC</b> <b>299 Frederick Road, Baltimore, MD 21228</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>4 years</b>		
a. <b>Dementia</b> Due to (or as a consequence of): { b. _____ c. _____ d. _____				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
29c. License number <b>142232</b>		29d. Date signed (Month, Day, Year) <b>9/6/11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Scott Reeser 103 Beta Blvd, Belcamp, MD 21017</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28329

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Sevier, Herbert  
Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		<b>Herbert Vincent Sevier</b>		Month Day Year		September 5, 2011 1:00 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		<b>Franklin Square Hospital Center</b>		<b>Rosedale</b>		<b>Baltimore</b>	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
		<b>215-28-6427</b>	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<b>79 Yrs.</b>		<b>Sept 18, 1931</b>	<b>Maryland</b>
To Be Completed by Funeral Director		Usual Residence of Decedent		10d. Inside City Limits			
		<b>Maryland</b>	<b>Baltimore</b>	<b>Essex</b>			
To Be Completed by Funeral Director		10a. State		10b. County		10c. City, Town or Location	
		<b>Maryland</b>		<b>Baltimore</b>		<b>Essex</b>	
To Be Completed by Funeral Director		10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
		<b>2512 Barrison Point Road</b>		<b>21221</b>		<b>USA</b>	
To Be Completed by Funeral Director		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
		<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>1955</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Specify:</b>
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry	
		<b>Elementary/Secondary (0-12) 12</b>		<b>Police Officer</b>		<b>Baltimore County</b>	
To Be Completed by Funeral Director		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
		<b>Walter O. Sevier Sr.</b>		<b>Mary-Jane E. Michael</b>			
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
		<b>Elva Sevier, Wife</b>		<b>2512 Barrison Point Road Essex, Maryland 21221</b>			
To Be Completed by Funeral Director		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
		<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	<b>Metro Crematory Inc.</b>		<b>09/06/11</b>	<b>Baltimore, Maryland</b>
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
		<b>Thomas Gregor</b>		<b>Cremation Society Of Maryland, Inc.</b>			
				<b>299 Frederick Road Baltimore, Maryland 21228</b>			
To Be Completed by Funeral Director		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
		Immediate Cause (Final disease or condition resulting in death)					
		a. <b>Health care associated pneumonia</b>					
		Due to (or as a consequence of):					
		b. _____					
		c. _____					
		d. _____					
To Be Completed by Funeral Director		Approximate Interval Between Onset and Death					
To Be Completed by Funeral Director		IF FEMALE:		23c. If yes, outcome of pregnancy		23d. Date of delivery	
		23b. Was decedent pregnant in the past 12 months?		<input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy	<input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	Month	Day
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown		Year	
To Be Completed by Funeral Director		23e. Did tobacco use contribute to the cause of death?					
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
To Be Completed by Funeral Director		24a. Was an autopsy performed?					
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Were autopsy findings available prior to completion of cause of death?					
To Be Completed by Funeral Director		24b. Were autopsy findings available prior to completion of cause of death?					
		<input type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director		25. Was case referred to medical examiner?		26. Place of Death (Check only one)			
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Funeral Director		27. Manner of Death		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
		<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			M	<input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Funeral Director		29a. Certifier		29b. Signature and title of certifier			
		<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number	
		<input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				<b>D72364</b>	
To Be Completed by Funeral Director		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature	
		<b>Devadatta Sarwate, M.D. 9000 Franklin Square Drive Baltimore, MD 21237</b>		<b>SEP 07 2011</b>			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28330

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Catherine Schleicher

2. Date of Death

Month 09 Day 01 Year 2011

3. Time of Death

12:45 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

8720 Ridge Road, Apartment 207

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

215-01-4081

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Mar 21

1918

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State Maryland

10b. County Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

8720 Ridge Road, Apt 207

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Hair Stylist

16b. Kind of Business Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Walter Fenton Buppert

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marguerite Cook

19a. Informant's Name/Relationship (Type, Print)

Emilie Martin - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Chappell Road, Dawsonville, GA 30534

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory INC

Date

09-02-2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Patricia M. Heming*

22. Name and Address of Facility

Cremation Society Of Maryland INC  
299 Frederick Road, Baltimore, MD 21228

Approximate  
Interval Between  
Incident and Death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dr. Marcelline D. Abasurine*

29c. License number

DR 9769

29d. Date signed (Month, Day, Year)

9/1/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Dr. Marcelline D. Abasurine 5160 Rockville Rd NW, Bethesda, MD 20814*

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

*Leanne M. Parker*

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

any injury or other traumatic event, the Medical Examiner must be notified at

once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28331

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Haynes Strouth</b>					2. Date of Death Month Sept. Day 02, Year 2011	3. Time of Death 9:00A M			
	4a. Facility Name (if not institution, give street and number) <b>Lorien Columbia</b>		4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>				
Funeral Director	5. Social Security Number <b>413.09.2419</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>03.03.1921</b>	9. Birthplace (State or Foreign Country) <b>TN</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Howard 10c. City, Town or Location Ellicott City						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>9640 Susies Way</b>			10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HomeMaker		16b. Kind of Business Industry <b>Own Home</b>					
	17. Father's Name (First, Middle, Last) <b>Noah Godsey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Nita Gertrude Carrier</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Sandra Pugh/Granddaughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9640 Susies WAyEllicott City, MD</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Linda Sue Ritter</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crownsville Vet.Cem.</b>		Date <b>09.07.11</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>				
	21. Signature of Funeral Service Licensee <i>Linda Sue Ritter</i>		22. Name and Address of Facility <b>Cremation and Funeral Alternatives/Stephen B Lohmann 8717 Green Pastures Drive Towson MD 21286</b>							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>years</b>		
	<p>a. <i>Coronary Artery Disease</i> Due to (or as a consequence of):</p> <p>b. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>c. <i>Congested Heart Failure</i> Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>R121680</b>							
	29b. Signature and title of certifier <i>Katherine Tautac CRNP</i>		29d. Date signed (Month, Day, Year) <b>Sept. 2 2011</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Katherine Tautac 6334 Cedar Lane Columbia MD 21044</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>James P. Farley</i>							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28332

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Hazel Valerie Shewell</b>						2. Date of Death Month <b>September</b> Day <b>3</b> Year <b>2011</b>			3. Time of Death 7:30 PM	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center for Hospice Care</b>						4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>219-12-0833</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days		If Under 24 Hrs. Hours <input type="checkbox"/> Min.		8. Date of Birth (Month, Day, Year) <b>Jan 08, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
		Usual Residence of Decedent <b>FL</b>		10a. State <b>FL</b>		10b. County <b>Marion</b>		10c. City, Town or Location <b>Ocala</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>9371-A SW 82nd Terrace</b>						10f. Zip Code <b>34481</b>		10g. Citizen of What Country? <b>United States</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
		17. Father's Name (First, Middle, Last) <b>John Edward Rickard</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Anna Catherine Sample</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Roger D. Shewell, Sr /Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11917 Meyston Drive ,Lutherville, MD 21093</b>			20c. Location - City or Town, State <b>Sep 06 2011 Beltsville, Maryland</b>				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Chesapeake Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State <b>Chesapeake Crematory</b>				
		21. Signature of Funeral Service Licensee <b>Linda Sue Bitter M01443</b>			22. Name and Address of Facility <b>Cremation and Funeral Alternatives</b> <b>8717 Green Pastures Drive Towson Maryland 21286</b>							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death				
		a. <b>Bladder Cancer</b> Due to (or as a consequence of):										
		b. _____ Due to (or as a consequence of):										
		c. _____ Due to (or as a consequence of):										
		d. _____										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		26. Place of Death (Check only one)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
		29b. Signature and title of certifier <b>M. D.</b>		29c. License number <b>D0071287</b>			29d. Date signed (Month, Day, Year) <b>9-4-11</b>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>										
		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Leanne J. Parker</b>								

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.** 2011 28333  
 State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

**Certificate of Death**

Reg. No.

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0930 hrs
William Harry Smith, IV		September 3, 2011

4a. Facility Name (if not institution, give street and number) 957 Regina Drive	4b. City, Town, or Location of Death Halethorpe	4c. County of Death Baltimore County
--	--	---

5. Social Security Number 214-86-7806	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 03/25/1964	9. Birthplace (State or Foreign Country) Maryland
--	--	---	---	---	--

10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Halethorpe	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
------------------------	--------------------------	---	--

10e. Street and Number 957 Regina Drive	10f. Zip Code 21227	10g. Citizen of What Country? United States
--	------------------------	--

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Delivery Driver	16b. Kind of Business/Industry Gifts
---	--	---

17. Father's Name (First, Middle, Last) William Harry Smith, III	18. Mother's Name (First, Middle, Maiden Surname) Joyce Smith
---	--

19a. Informant's Name/Relationship (Type, Print) Joyce Smith / Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 957 Regina Drive, Halethorpe, Maryland 21227
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.	Date 09/06/2011	20c. Location - City or Town, State Baltimore, Maryland
---	--	--------------------	--

4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Alyson K Taylor</i>	22. Name and Address of Facility Cremation Society of Maryland
---	---

299 Frederick Rd., Baltimore, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <u>Heroin Intoxication</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
--	--	--

d. <input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g920 10-3-11 sm	
--	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		
---	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 9-3-11	28b. Time of Injury fd 9:20 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
--	---	-----------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 957 Regina Ave. Arbutus, Md.
--	---

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input checked="" type="checkbox"/> Medical Examiner	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
---	---	--	--

29b. Signature and title of certifier <i>Mary G. Ripple MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 4, 2011
---	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) SEP 07 2011	32. Registrar's Signature <i>Laura S. Jackson</i>
--	--

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

OCME

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28334

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0122 hrs
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William Harrison Smith

Reg. No.

4a. Facility Name (if not institution, give street and number) 17300 Big Falls Road	4b. City, Town, or Location of Death Monkton	4c. County of Death Baltimore County
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August 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28335

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond Layfayette Stancill Jr.</b>				2. Date of Death Month Day Year <b>August 31, 2011</b>	3. Time of Death 6:26 P M
	4a. Facility Name (if not institution, give street and number) <b>Stella Maris Hospice</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>219-18-2322</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b> </b>	8. Date of Birth (Month, Day, Year) <b>May 30, 1924</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Aberdeen</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>3421 James Run Road</b>			10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business Industry <b>Construction</b>	
	17. Father's Name (First, Middle, Last) <b>Raymond Layfayette Stancill Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy Mae Lewis</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Evelyn D. Gross / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3421 James Run Road, Aberdeen, Maryland 21001</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gdn.</b>		Date <b>09-03-11</b>	20c. Location - City or Town, State <b>Aberdeen, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>			
	Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				
Medical Certificate: To Be Completed by Physician/Medical Examiner	<p>a. <b>END STAGE DEMENTIA</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D43725</b>				
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>9/1/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TARIQ MAHMOOD, MD - 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>						
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 				

ORIGINAL

AUGUST 31, 2011 6:26 p.m.

Baltimore, Maryland 21215-0036

RAYMOND STANCI

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28336

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Norma (nmn) Schatzschneider</b>					2. Date of Death Month Day Year <b>September 3, 2011</b>	3. Time of Death <b>2:30 PM</b>	
	4a. Facility Name (if not institution, give street and number) <b>Upper Chesapeake Medical Center</b>			4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>057-12-0484</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1916</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Bel Air</b>	
	10e. Street and Number <b>2914 Penwood Court</b>			10f. Zip Code <b>21015</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>			16b. Kind of Business Industry <b>Glass Manufacturing</b>	
	17. Father's Name (First, Middle, Last) <b>Pietro (unk) Croce</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine (unk) Nicolini</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Wallace G. Schatzschneider/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2914 Penwood Court, Bel Air, Maryland 21015</b>				
Physician/ Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cem.</b>			Date <b>9/7/2011</b>	
	21. Signature of Funeral Service Licensee <b>Barbara L. Pudie</b>			22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>			20c. Location - City or Town, State <b>Woodlawn, Maryland</b>	
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE STROKE</b> Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): <b>ATRIAL FIBRILLATION</b>							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Andrew Nowakowski MD</b>	29c. License number <b>D08096</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 3, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREW NOWAKOWSKI MD 35 FULFORD AVE. BELAIR, MD 21014</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature <b>Anna S. Patel</b>						

Baltimore, Maryland 21215-0036  
9/3/11 1430  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28337

**1- For State Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Anna Barbara Soboleski</b>					2. Date of Death Month Day Year <b>August 29, 2011</b>	3. Time of Death 0930 hrs		
<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>1205 Hanson Road</b>			4b. City, Town, or Location of Death <b>Edgewood</b>		4c. County of Death <b>Harford</b>			
<b>To Be Completed by Funeral Director</b>	5. Social Security Number <b>138-14-6806</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>June 18, 1915</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Reisterstown</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>215 Persimmon Circle</b>			10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>USA</b>			
<b>Physician/ Medical Examiner</b>	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>8</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business/Industry <b>Clothing Manufacturer</b>		
	17. Father's Name (First, Middle, Last) <b>Joseph (nnm) Misiewicz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary (nnm) Labuza</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Karen Furman / Granddaughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21136 215 Persimmon Circle, Reisterstown, Maryland</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Trinity Cemetery</b>		Date <b>9/2/2011</b>	20c. Location - City or Town, State <b>Hopelawn, New Jersey</b>			
	4. <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify <b>Marilyn Amy</b>		22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b>		1317 Cokesbury Road, Abingdon, Maryland 21009				
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	23a. Part I. Enter the disease, or condition(s), that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED							Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 31, 2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>								
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28338

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death	3. Time of Death	
	Maria Anna Scheck				Month Aug Day 29 Year 2011	3:25 AM	
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>Genesis HealthCare - The Pines</b>			4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
	5. Social Security Number <b>129-30-1529</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) <b>04/03/1940</b>
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. State <b>MD</b>	10b. County <b>Queen Annes</b>	10c. City, Town or Location <b>Centreville</b>				
10e. Street and Number <b>165 Symphony Way</b>			10f. Zip Code <b>21617</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerical</b>		16b. Kind of Business Industry <b>Law Enforcement</b>			
17. Father's Name (First, Middle, Last) <b>Giuseppe Lacono</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Scheck / Sister in Law</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 66, Treadwell, NY 13846</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Anatomy Gifts Registry</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomy Gifts Registry</b>		Date <b>09/02/2011</b>	20c. Location - City or Town, State <b>Hanover, Maryland</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Adult failure to thrive</i> Approximate Interval Between Onset and Death <i>weeks</i>							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 							
29c. License number <b>JL5933</b>							
29d. Date signed (Month, Day, Year) <b>8-29-11</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Michael D. Crowley, MD, 610 Dutchmans Lane, Easton, MD 21607</b>							
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28339

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 08 Day 22 Year 2011		3. Time of Death 0918 AM
ANALIYAAH SINGH				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
HOLY CROSS HOSPITAL				
5. Social Security Number <input checked="" type="checkbox"/> W M K		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months 1 Days 1 Hours 0 Min. 8. Date of Birth (Month, Day, Year) 08/21/2011
				9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State MD 10b. County MONTGOMERY 10c. City, Town or Location ROCKVILLE 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 4512 FALCON ST		10f. Zip Code 20853		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A INFANT		16b. Kind of Business Industry INFANT
17. Father's Name (First, Middle, Last) MAHINDRA HARI PRASHAD		18. Mother's Name (First, Middle, Maiden Surname) NADIRIA SINGH		
19a. Informant's Name/Relationship (Type, Print) HOLY CROSS HOSPITAL		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 FOREST GLEN RD SILVER SPRING MD 20910		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensee ► Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 30 hrs		
a. RESPIRATORY FAILURE Due to (or as a consequence of):				
b. PULMONARY HYPOPLASIA Due to (or as a consequence of):		30 hrs		
c. PREMATURITY Due to (or as a consequence of):		30 hrs		
d. PROLONGED PROM		2 MO		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPOTENSION		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D666486		
29b. Signature and title of certifier ► Gerni Baer nup		29d. Date signed (Month, Day, Year) 8/22/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERRI BAER 1500 FOREST GLEN RD SILVER SPRING MD 20910				
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Sarah S. Parker		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28340

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Arthur Singer</b>					2. Date of Death Month 8 Day 17 Year 2011	3. Time of Death 8:00 P M	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>					4b. City, Town, or Location of Death <b>Rosedale</b>	4c. County of Death <b>Baltimore</b>	
<b>Funeral Director</b>	5. Social Security Number <b>219-42-2329</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>66 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 18, 1945</b>	9. Birthplace (State or Foreign Country) <b>UNK</b>	
Usual Residence of Decedent 10a. State MD 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <b>1 Yes 2 No</b>								
10e. Street and Number <b>5531 Todd Avenue</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>		
<b>To Be Completed by Funeral Director</b>	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: <b>unk</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 □ No Specify: <b>white</b>		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>		16c. Date of Death <b>unk</b>	
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Franklin Square Hospital</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9000 Franklin Square Dr Rosedale, MD 21237</b>			
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>unk</b>		Date	20c. Location - City or Town, State <b>unk</b>		
	21. Signature - Funeral Service License <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
<b>Physician /Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Lung Carcinoma</b> Approximate Interval Between Onset and Death							
	23b. Part 2. Enter the disease, or complications that contributed to the death but did not result in the underlying cause. List only one cause on each line. Sequentially list conditions, starting with immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Pneumonia</b> Due to (or as a consequence of): a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>								
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown								
24a. Was an autopsy performed? 1 □ Yes 2 □ No				24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical examiner? 1 □ Yes 2 □ No								
26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
27. Manner of Death 1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Laura Steele</b>				29c. License number <b>D57721</b>		29d. Date signed (Month, Day, Year) <b>8/17/11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Laura Steele 9000 Franklin Square Drive Baltimore, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Laura P. Steele</b>						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Arthur  
Singer  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28341

**1- For  
State  
Registrar**

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

Baltimore, Maryland 21215-0036  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>Matthew William Scott</b>			2. Date of Death Month <b>August</b> Day <b>27</b> , Year <b>2011</b>	3. Time of Death <b>11:30 AM</b>
4a. Facility Name (if not institution, give street and number) <b>Wilson Haven Facility</b>			4b. City, Town, or Location of Death <b>Baltimore</b>	
4c. County of Death				
5. Social Security Number <b>212-74-4934</b>		6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>90 Yrs.</b>	If Under 1 Year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
8. Date of Birth (Month, Day, Year) <b>Jan 5, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
10a. State <b>MD</b>		10b. County		10d. Inside City Limits <b>1 X Yes 2 □ No</b>
10c. City, Town or Location <b>Baltimore</b>				
10e. Street and Number <b>1817 E. 30th Street</b>			10f. Zip Code <b>21218</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No If Yes, Give Year or Dates.</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify: black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) unk</b>	unk	16b. Kind of Business Industry <b>Food industry</b>
17. Father's Name (First, Middle, Last) <b>William Henry Scott</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Syrus</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Alberta Wilson/caregiver</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1927 E. 30th Street Baltimore, MD 21218</b>		
20a. Method of Disposition <b>1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 X Other (Specify) in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>Lung Cancer</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 X No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) _____ 9 □ Unknown</b>		
23d. Date of delivery Month _____ Day _____ Year _____				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Hyp Schizophrenia</i>				
23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>				
24a. Was an autopsy performed? <b>1 □ Yes 2 X No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b>		
25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 X Other (Specify) facility</b>		
27. Manner of Death <b>1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of injury (Month, Day, Year) <b>MM</b>	28b. Time of injury <b>M</b>	28c. Injury at work? <b>1 □ Yes 2 □ No</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D17537</b>		
29b. Signature and title of certifier <b>D. S. Salviya</b>		29d. Date signed (Month, Day, Year) <b>8-30-11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DARSHAN S. SALVIYA MD 6821 Reisterstown Rd, Baltw 21217</b>				
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>James A. Jacobs</b>		

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28342

Reg. No.

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0955 hrs
--	------------------------------------	------------------------------

Richard Donald Schattl

August 14, 2011

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number) 2917 Eastern Boulevard	4b. City, Town, or Location of Death Essex	4c. County of Death Baltimore County
--	---	---

5. Social Security Number  unk 6. Sex  M  F 7. Age (In yrs. last birthday) 73 Yrs.

If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) Feb 21, 1938	9. Birthplace (State or Foreign Country) Maryland
---------------------------	--------------------------	---	--

Usual Residence of Decedent  
10a. State MD 10b. County Baltimore 10c. City, Town or Location Essex

10d. Inside City Limits  
 Yes  No

10e. Street and Number 2917 Eastern Blvd 10f. Zip Code 21220 10g. Citizen of What Country? USA

11. Marital Status  
1  Never Married 2  Married 12. Was Decedent Ever in U.S.  
Armed Forces?  
1  Yes 2  No  
3  Widowed 4  Divorced If Yes, Give Year  
or Dates:  
1  Yes 2  No specify:  
Specify: white

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)  
contractor 16b. Kind of Business/Industry  
electrical

17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk

19a. Informant's Name/Relationship (Type, Print)  
Christine Schattl/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
5027 Orville Avenue Baltimore, MD 21205

20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other Specify: in state

20b. Place of Disposition (Name of cemetery,  
crematory or other place) Date 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee  
Ronald S. Wade, Director 22. Name and Address of Facility  
State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease  
Due to (or as a consequence of):

b. \_\_\_\_\_  
Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

UNPENDED  AMENDED

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No 9  Unknown 23c. If yes, outcome of pregnancy  
1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism; Lung Cancer  
23e. Did tobacco use contribute to the cause of death?  
1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

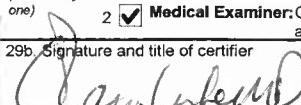
25. Was case referred to medical examiner?  
1  Yes 2  No Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other: Scene

27. Manner of Death  
1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

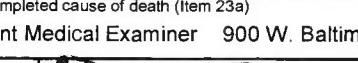
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?  
1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc.  
(Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier  29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)  
August 15, 2011

30. Name and address of person who completed cause of death (Item 23a)  
Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) SEP 07 2011 32. Registrar's Signature  ORIGINAL

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28343

1 - For State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a & show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year			3. Time of Death	
		Teresa Schmidt						July 11, 2011			9:54 AM <sup>M</sup>	
Physician / Medical Examiner		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
		1431 Gittings Avenue			Baltimore			Baltimore				
Funeral Director		5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 24, 1957	9. Birthplace (State or Foreign Country) Maryland			
		Usual Residence of Decedent		10a. State MD			10b. County Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 1431 Gittings Avenue			10f. Zip Code 21239			10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) caregiver		16b. Kind of Business/Industry healthcare						
		17. Father's Name (First, Middle, Last) Richard Lee McGill			18. Mother's Name (First, Middle, Maiden Surname) Camilla Benson							
		19a. Informant's Name/Relationship (Type, Print) Camilla Royer/mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1127 Uniontown Road Westminster, MD 21158							
Physician / Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State				
		21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201								
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Coronary Artery Disease (possible)			Approximate Interval Between Onset and Death					
				23c. Due to (or as a consequence of): hypertension								
				23d. Due to (or as a consequence of): hyperlipidemia								
				23e. Due to (or as a consequence of): diabetes								
		23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
				23e. 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____								
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. bipolar disorder					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier Lisa Keamy MD		29c. License number D45575			29d. Date signed (Month, Day, Year) 7/14/2011 + 8/18/11					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Keamy MD 6080 Falls Rd Suite 204 Balt MD 21209										
State Registrar		31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature Laura S. Parker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

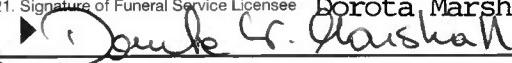
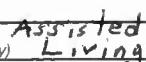
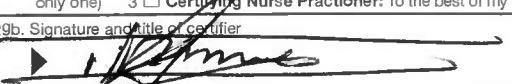
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28344

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		Hallie Smallwood			2. Date of Death Month September Day 2, Year 2011	3. Time of Death 7:59 P M
4a. Facility Name (if not institution, give street and number) Rita's Adult Home Care		4b. City, Town, or Location of Death Capitol Heights			4c. County of Death Prince George's	
5. Social Security Number 577-26-7176		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 08/08/1915	9. Birthplace (State or Foreign Country) SC
Usual Residence of Decedent						
10a. State MD	10b. County Prince George's	10c. City, Town or Location Capitol Heights			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1501 Brooke Road		10f. Zip Code 20743			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse's Assistant			16b. Kind of Business Industry Healthcare	
17. Father's Name (First, Middle, Last) Harold Jones		18. Mother's Name (First, Middle, Maiden Surname) unkn.				
19a. Informant's Name/Relationship (Type, Print) Maria Simmons/Granddaughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9416 Wyatt Dr., Lanham, MD 20706				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake crematory			Date 9/7/2011	20c. Location - City or Town, State Beltsville, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)   Approximate Interval Between Onset and Death						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of):  </p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) 			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D70102			29d. Date signed (Month, Day, Year) 09-04-2011	
29b. Signature and title of certifier 						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivan Simms, MD, 19200 Basil Ct, Suite 200, Langley, MD 20774						
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28345

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Charles H. Stansburge

III

2. Date of Death

Month Day Year

September 4, 2011

3. Time of Death

7:00 AM

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

839 Randolph Drive

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

5. Social Security Number

217-54-3999

6. Sex

M

F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

November 22, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Florida

10b. County

Saint Lucie

10c. City, Town or Location

Fort Pierce

10d. Inside City Limits

Yes  No

10e. Street and Number

13930 Aguila

10f. Zip Code

34951

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Labor Leader

16b. Kind of Business Industry

Teamster Union 570

17. Father's Name (First, Middle, Last)

Charles H. Stansburge Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Jane Sophia Marie King

19a. Informant's Name/Relationship (Type, Print)

Sandra Stansburge wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13930 Aguila, Fort Pierce, Florida 34951

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

September 6, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD 21222

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of): PANCREATIC CANCER

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
g  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (specify) DAUGHTERSHUSE

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. JONES CRNP

29c. License number

R149792

29d. Date signed (Month, Day, Year)

9/6/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIE JONES CRNP 2300 SULLANEY VALLEY RD TOWSON, MD 21093

31. Date filed (Month, Day, Year)

SEP 07 2011

32. Registrar's Signature

Debra A. Parker

State Registrar

September 4, 2011

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trust

CHALLES STANSBURGE

Division of Vital Records, P.O. Box 68760

10

CHARLES STANSBURGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28346

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death				
<i>Elizabeth Sheppard</i>		Month <i>September</i> Day <i>4</i> Year <i>2011</i>		19:58 M				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
<i>MERCY MEDICAL CENTER</i>		<i>Baltimore MD</i>		<i>Baltimore</i>				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Country VA.	
<i>214-12-8324</i>		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	92 Yrs.			<i>July 24, 1919</i>		
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MD				<i>Baltimore</i>				
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?		
<i>1400 E. Madison St. Apt. 1101</i>				<i>21205</i>		<i>USA</i>		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced								
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry				
Elementary/Secondary (0-12) <i>9th</i>		College (1-4 or 5+) <i>Custodian</i>		<i>Baltimore Country Club</i>				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
<i>Emmanuel Sharp</i>		<i>Alice Allen</i>						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
<i>Sarah Bush (niece)</i>		<i>920 Mt. Holly St. Baltimore, Md. 21229</i>						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		<i>Garrison Forest</i>		<i>Sept. 12, 2011 Owings Mills, Md.</i>				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
<i>[Signature]</i>		<i>Calvin B. Scruggs Funeral Home</i> <i>1412 E. Preston St. Balto, Md. 21213</i>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death						
Immediate Cause (Final disease or condition resulting in death)		<i>GASTROINTESTINAL BLEEDING</i>						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <i>ANORECTAL CANCER, PRESUMED METASTATIC</i>						
{		b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)		27. Manner of Death				
		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one)		29b. Signature and title of certifier <i>[Signature]</i> <i>PHYSICIAN</i>		29c. License number <i>NPI 1396073706</i>	29d. Date signed (Month, Day, Year) <i>09 (September), 4, 2011</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) <i>SEP 07 2011</i>		32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

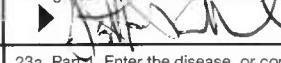
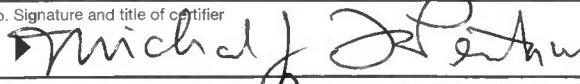
amend 18, per fh, 919 9-12-11 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28347

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>LEAH J. SPARKS</i>				2. Date of Death Month 09 Day 31 Year 2011	3. Time of Death M 1845 M		
	4a. Facility Name (if not institution, give street and number) 7813 Elberta Drive		4b. City, Town, or Location of Death Severn		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 232-29-6283	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 30, 1972	9. Birthplace (State or Foreign Country) Ohio		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Hanover					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7717 Baggins Rd.		10f. Zip Code 21076		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Intelligence Agent			16b. Kind of Business Industry Federal Govnernment		
	17. Father's Name (First, Middle, Last) Kelly S. Sparks			18. Mother's Name (First, Middle, Maiden Surname) Myra F. Holtsclaw				
	19a. Informant's Name/Relationship (Type, Print) Kelly S. Sparks / Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7813 Elberta Dr., Severn, Maryland 21144					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baldwin Mem. Ch. Cem.		Date Sept. 3, 2011	20c. Location - City or Town, State Millersville, Maryland		
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Belinic Sarcoma</i>			Approximate Interval Between Onset and Death 44 years		
	a. Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number D21438		29d. Date signed (Month, Day, Year) September 01 2011			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MICHAEL J. LAPENTA</i>		31. Date filed (Month, Day, Year) SEP 07 2011					
			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28348

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Taylor</b>			2. Date of Death Month <b>September</b> Day <b>2</b> Year <b>2011</b>			3. Time of Death <b>2051 M</b>				
	4a. Facility Name (if not institution, give street and number) <b>The Johns Hopkins Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore City</b>			4c. County of Death				
Funeral Director	5. Social Security Number <b>220-84-8579</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>Feb 14, 1967</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Joppa</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>990 Rumsey Place</b>			10f. Zip Code <b>21085</b>			10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business Industry <b>Commodities</b>					
	17. Father's Name (First, Middle, Last) <b>Ralph A. Taylor</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Larissa D. Blevins</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Michelle Taylor /Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>990 Rumsey Place Joppa, MD 21085</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Chesapeake Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>			Date <b>Sep 06, 2011</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Superior Cremation</b> MO1443			22. Name of Crematory and Funeral Alternatives <b>8717 Green Pastures Drive Towson Maryland 21286</b>							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CARDIOPATHY</b>								Approximate Interval Between Onset and Death		
	a. Due to (or as a consequence of): <b>Thrombosis in lungs</b>										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
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				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	29b. Signature and title of certifier <b>Gobind Anan</b>			29c. License number <b>RES 000</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2 2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 N. Wolfe St, Baltimore, MD 21287</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Leanne J. Powell</b>								

Baltimore, Maryland 21215-0036

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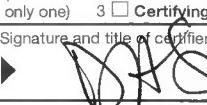
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 28349

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Howard Thompson</b>				2. Date of Death Month <b>September</b> Day <b>4</b> , Year <b>2011</b>		3. Time of Death <b>6:15 A.M.</b>		
					4b. City, Town, or Location of Death <b>Sudlersville</b>		4c. County of Death <b>Queen Anne's</b>		
Funeral Director	5. Social Security Number <b>213-44-0124</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>05/16/1945</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent <b>MD Queen Anne's</b>		10c. City, Town or Location <b>Sudlersville</b>						
	10e. Street and Number <b>113 Charles Street, Apt. 1B</b>			10f. Zip Code <b>21668</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction</b>				
	17. Father's Name (First, Middle, Last) <b>Charles H. Thompson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Len Rebecca Walls</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Wanda Thompson/Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Charles St., Apt. 1B, Sudlersville, MD</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake crematory</b>		Date <b>9/8/2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Maryland Cremation Services PO box 1413, Baltimore, MD 21203</b>						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>melanoma</b>							Approximate Interval Between Onset and Death <b>5 years</b>	
	<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): _____</p> <p>b. Due to (or as a consequence of): _____</p> <p>c. Due to (or as a consequence of): _____</p> <p>d. _____</p>								
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number <b>D39887</b>		29d. Date signed (Month, Day, Year) <b>9/6/11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Smith MD 822 Teal Drive, Suite 301 Easton MD</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificates be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28350

1. For State  
Registrar**Physician/  
Medical  
Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Daniel Brian Trageser</b>			2. Date of Death Month Day Year <b>September 5, 2011</b>	3. Time of Death 1544 hrs	
4a. Facility Name (if not institution, give street and number) <b>6123 Marg Glenn Avenue</b>			4b. City, Town, or Location of Death <b>Overlea</b>	4c. County of Death <b>Baltimore County</b>	
5. Social Security Number <b>215-88-0687</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months Days Hours Min.    	8. Date of Birth (MM/DD/YYYY) <b>July 21, 1963</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Dundalk</b>		
10e. Street and Number <b>7414 St. Patricia Court</b>			10f. Zip Code <b>21222</b>	10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 years</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Installer</b>	16b. Kind of Business/Industry <b>Carpet Company</b>			
17. Father's Name (First, Middle, Last) <b>Ronald P. Trageser</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Showacre</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Charlotte Showacre Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7414 St. Patricia Court, Dundalk, Md. 21222</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Anthony Connely</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>September 7, 2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee <i>Anthony Connely</i>					
22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A. 7110 Sellers Point Road Dundalk, Md. 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition resulting in death) a. <b>Methadone Intoxication</b> Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, pt. II, 27, 28a-f, per me, g919 9-19-11 sm				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
23f. Cocaine Use _____			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>fd 9-5-11</b>	28b. Time of Injury <b>fd 3:31 pm</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Unknown</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence of Friend</b>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6123 Marg Glenn Ave. Overlea, Md.</b>					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Zabiullah Ali</i>			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 6, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>					
31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>					
32. Registrar's Signature <i>James J. Gable</i>					

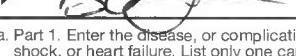
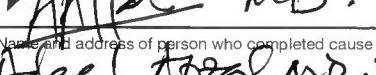
ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2012835

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>MARIAN VOTAVA</b>						2. Date of Death Month <b>09</b> Day <b>oct</b> Year <b>2011</b>	3. Time of Death <b>1645 P M</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>1005 Debbie Avenue</b>			4b. City, Town, or Location of Death <b>Essex</b>			4c. County of Death <b>Baltimore</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>214-20-7069</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>04/14/1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
		Usual Residence of Decedent <b>MD Baltimore</b>		10a. State <b>MD</b> 10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number <b>1005 Debbie Avenue</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Homemaker</b>		16c. Location - City or Town, State <b>Own Home</b>		
		17. Father's Name (First, Middle, Last) <b>Harry Leibold</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Edward J. Votava / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Debbie Avenue, Essex, MD 21221</b>						
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomy Gifts Registry</b>		Date <b>09/07/2011</b>	20c. Location - City or Town, State <b>Hanover, Maryland</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Anatomy Gifts Registry</b> <b>7522 Connelley Dr., Ste. P, Hanover, MD 21076</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{		a. Due to (or as a consequence of): <b>Severe Debility</b>	b. Due to (or as a consequence of): _____	c. Due to (or as a consequence of): _____	d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D67220</b>		29d. Date signed (Month, Day, Year) <b>9/5/2011</b>				
30. Name and address of person who completed cause of death (Item 22) (Type, Print) <b>Debel Votava, md. 2835 Sunn Ave. #203, Baltimore, MD.</b>		31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature 						
State Registrar										

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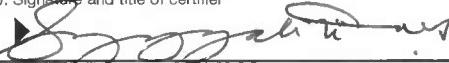
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28352

Reg. No.

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ernest Jacob Wyatt</b>					2. Date of Death Month <b>09</b> Day <b>06</b> Year <b>2011</b>	3. Time of Death 2055 p M		
	4a. Facility Name (if not institution, give street and number) <b>3920 Baltimore St.</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>216-42-8510</b>	6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) <b>05/24/1945</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Baltimore</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3920 Baltimore St.</b>			10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business Industry <b>Transportation</b>		
	17. Father's Name (First, Middle, Last) <b>Ernest Lee Wyatt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Neva Mossman</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Bonnie E. Wyatt / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3920 Baltimore St., Baltimore, MD 21227</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>W. Arundel Crematory</b>		Date <b>09/12/2011</b>	20c. Location - City or Town, State <b>Odenton, MD</b>			
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227</b>						
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cerebro Vascular Accident</b>						Approximate Interval Between Onset and Death <b>1 to 2 years</b>		
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 						29c. License number <b>D0040491</b>	29d. Date signed (Month, Day, Year) <b>9-7-2011</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Syed Nea Riaz MD 518 S Comp Neade Rd. Linthicum Md 21090</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28353

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**Mary Ann Wickwire**

2. Date of Death

Month

Day

Year

SEPTEMBER 5, 2011

3. Time of Death

3:00 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

**Saint Joseph Medical Center**

4b. City, Town, or Location of Death

**Towson**

4c. County of Death

**Baltimore**

5. Social Security Number

**044-24-5302**

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

**95**

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

**Sept. 25, 1915**

9. Birthplace (State or Foreign Country)

**Luck, Wisconsin**

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

**Maryland****Baltimore County****Cockeysville**

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

**13801 York Road**

10f. Zip Code

**21030**

10g. Citizen of What Country?

**United States**

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
**12**College (1-4 or 5+)  
**06**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**School Teacher**

16b. Kind of Business Industry

**Baltimore County Public Schools**

17. Father's Name (First, Middle, Last)

**Gerhart Herwick**

18. Mother's Name (First, Middle, Maiden Surname)

**Tekla Rowe**

19a. Informant's Name/Relationship (Type, Print)

**Brian M. Wickwire (Son)**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**717 Highland Ave. McAllen, (Hidalgo Co.) Texas 78501**

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Evans Funeral Chapel and Cremation Services, Inc.**

Date

**Tuesday, Sept. 06, 2011**

20c. Location - City or Town, State

**(Harford County) Forest Hill, Maryland**

21. Signature of Funeral Service Licensee

**Jeffrey L. Gair, Sr. CFSP**  
Lic. #M00677

Name and Address of Facility

**Peaceful Alternatives Funeral and Cremation Center, P.A.****2325 York Road Timonium, Maryland 21093-2215**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

**10 DAYS****ARRHYTHMIA**

Due to (or as a consequence of):

**RESPIRATORY FAILURE**

b. Due to (or as a consequence of):

**SEPSIS**

Due to (or as a consequence of):

**10 DAYS**

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DCA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

**J. M. Linker, M.D.****MD**

29c. License number

**D39858**

29d. Date signed (Month, Day, Year)

**SEPTEMBER 5 2011**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**MARTIN R. LINKER, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204**

31. Date filed (Month, Day, Year)

**SEP 07 2011**

32. Registrar's signature

**Debra J. Parker**Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #10e, 16a&b Per Th G919 9/07/2011

State of Maryland / Department of Health and Mental Hygiene

2011 28354

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>09</u> Day <u>05</u> Year <u>11</u>		3. Time of Death <u>02:21 AM</u>
<u>Rudolph Williams</u>				
4a. Facility Name (if not institution, give street and number) <u>University of Maryland Medical Center</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death
5. Social Security Number <u>212-60-6479</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>58</u> Yrs.	If Under 1 Year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
8. Date of Birth (Month, Day, Year) <u>11/16/1952</u>		9. Birthplace (State or Foreign Country) <u>MD</u>		
10a. State <u>MD</u>		10b. County		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <u>H2 N. Poppe</u>		10f. Zip Code <u>21201</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th</u>		16a. Decedent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired) Maintenance		16b. Kind of Business Industry <u>Health Care</u>
17. Father's Name (First, Middle, Last) <u>Joseph Brown</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Brown</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Dwayne S. Williams Sr. Son</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9004 Wilbur Avenue Randallstown, MD 21133</u>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u>MT. Carmel</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MT. Carmel</u>		Date <u>9/15/11</u>
21. Signature of Funeral Service Licensee <u>Vaughn C. Greene</u>		22. Name and Address of Facility <u>Vaughn C. Greene F.S. Randallstown, MD 21133</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <u>Septic Shock</u> Due to (or as a consequence of):</p> <p>b. <u>Pneumonia</u> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Squamous cell carcinoma of the head/neck metastatic to liver</u>				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27.. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <u>1275822 876</u>		
29b. Signature and title of certifier <u>Filipa A. Ligeiro</u>		29d. Date signed (Month, Day, Year) <u>09/05/11</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Filipa A. Ligeiro, MD 22 S. Greene St. Baltimore, MD 21201</u>				
31. Date filed (Month, Day, Year) <u>SEP 07 2011</u>		32. Registrar's Signature <u>Leanne S. Parker</u>		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #205, per FRH, G919, 9/7/2011 WS

State of Maryland / Department of Health and Mental Hygiene

2011 28355

## Certificate of Death

Reg. No.

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCILLE ANN WOOD</b>				2. Date of Death Month Day Year <b>Sept 3, 2011</b>	3. Time of Death 4:15 A M	
	4a. Facility Name (if not institution, give street and number) <b>Glen Burnie Health &amp; Rehabilitation Center</b>		4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>214-20-3571</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Days <b> </b>	8. Date of Birth (Month Day Year) <b>Aug 9, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
	10e. Street and Number <b>673 East Clement Street</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 1 Homemaker</b>		16b. Kind of Business Industry <b>Housewife &amp; Mother</b>		
	17. Father's Name (First, Middle, Last) <b>Alfred Epp</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Ihle</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Marlene A. Bisesi (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12102 Church Lane, Cordova, Maryland 21625</b>				
Physician/ Medical Examiner	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		<b>9/7/2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Kevin E Ecker</b>		22. Name and Address of Facility <b>McCullly-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230-4318</b>				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	<p>a. <b>advanced Dementia</b> Due to (or as a consequence of):</p> <p>b. <b>Hypertension</b> Due to (or as a consequence of):</p> <p>c. <b>Degenerative joint disease</b> Due to (or as a consequence of):</p> <p>d. <b> </b></p>						
	Approximate Interval Between Onset and Death <b>5 years</b> <b>&gt;2 years</b> <b>&gt;2 years</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Pneumonia</b> <b>Recurrent urinary tract infection</b>						
	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>						
	24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						
	26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>						
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>						
	28a. Date of injury (Month, Day, Year) <b> </b> 28b. Time of injury <b>M</b> 28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> 28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>						
	29b. Signature and title of certifier <b> </b> 29c. License number <b>D0066019</b> 29d. Date signed (Month, Day, Year) <b>Sep. 6th 2011</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5505 E Ritchie Hwy Lamader Brooklyn MD 21225</b>						
	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>James J. Farley</b>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/23a, ptI&amp;II, 24a, perpHYS, G919, 9/7/2011, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28356

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donald L. Walston, Jr.</b>							2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>2011</b>	3. Time of Death <b>0911 P M</b>	
	4a. Facility Name (if not institution, give street and number) <b>Baltimore Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>216-60-7510</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Mar 10, 1952</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Linthicum Heights</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>303 Greenwood Road</b>			10f. Zip Code <b>21090</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Welder Mechanic</b>			16b. Kind of Business Industry <b>Industrial</b>				
	17. Father's Name (First, Middle, Last) <b>Donald L. Walston, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Mae Seligman</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Dolores C. Walston - WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Greenwood Road, Linthicum Heights, MD 21090</b>					
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory INC</b>			Date <b>9-1-2011</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Patricia McSweeney</i>		22. Name and Address of Facility <b>Cremation Society Of Maryland INC</b> <b>299 Frederick Road, Baltimore, MD 21228</b>							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Chronic Obstructive Pulmonary Disease</b>								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Congestive Heart Failure</b>									
	b. Due to (or as a consequence of): <b>END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>									
	c. Due to (or as a consequence of): <b>RENAL FAILURE</b>									
	d.									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Disease</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>13-45149</b>			29d. Date signed (Month, Day, Year) <b>August 22, 2011</b>				
	29b. Signature and title of certifier <i>Donald L. Walston Jr.</i>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald L. Walston Jr.</b>									
	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <i>Patricia McSweeney</i>							

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

100-1000

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28357

1. For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

1. Decedent's Name (First, Middle, Last) <b>Emily P. Wissler</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2011</b>				3. Time of Death 9:35p M			
4a. Facility Name (if not institution, give street and number) <b>Dulaney Valley Assisted Living</b>				4b. City, Town, or Location of Death <b>Cockeysville</b>				4c. County of Death <b>Baltimore</b>			
5. Social Security Number <b>466-10-7110</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Sept. 24, 1917</b>	9. Birthplace (State or Foreign Country) <b>Texas</b>				
Usual Residence of Decedent											
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Cockeysville</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>6 E. Honey Bee Court</b>				10f. Zip Code <b>21030</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Claims Examier</b>				16b. Kind of Business Industry <b>Social Security</b>			
17. Father's Name (First, Middle, Last) <b>Julius Piper</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Ulmann</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mark Krieger Sr. /grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1548 Aldenry Avenue Baltimore MD 21220</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Bayview Crematory</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>				Date <b>9/3/11</b>	20c. Location - City or Town, State <b>Baltimore MD</b>		
21. Signature of Funeral Service Licensee <b>Peter J. Burns</b>				22. Name and Address of Facility <b>300 Mace Ave. Balto. MD Connely Funeral Home of Essex 21221</b>							

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) <b>END STAGE DEMENTIA</b>									
Approximate Interval Between Onset and Death <b>&gt;5 years</b>									
23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. Due to (or as a consequence of): <b>END STAGE DEMENTIA</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									

IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
------------	--	---	--	--	--	---	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ALF</b>					
27. Manner of Death <b>Natural</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D32717</b>				29d. Date signed (Month, Day, Year) <b>9/03/2011</b>	
---	--	--------------------------------------	--	--	--	---	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO A DELGADO</b>				32. Registrar's Signature <b>SEP 07 2011</b>			
---	--	--	--	---	--	--	--

31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>	32. Registrar's Signature <b>Amber J. Jackson</b>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28358

Certificate of Death

Reg. No.

1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

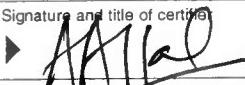
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year		3. Time of Death			
<b>ROBERT WRIGHT</b>			08 28 2011		1028 AM			
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death			
<b>Future Care Canton Harbor</b>			<b>Baltimore</b>					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 25, 1936	9. Birthplace (State or Foreign Country) Maryland		
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1817 Fleet Street			10f. Zip Code 21231		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrician		16b. Kind of Business/Industry Bethlehem Steel			
17. Father's Name (First, Middle, Last)			unk		18. Mother's Name (First, Middle, Maiden Surname) unk			
19a. Informant's Name/Relationship (Type, Print) Eleanor Thomas/friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 S. Collington Avenue Baltimore, MD 21224					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald J. Wade, Director			22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death					
a. <b>Oropharyngeal Squamous Cell Cancer</b> Due to (or as a consequence of):								
b. _____ Due to (or as a consequence of):								
c. _____ Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier 			29c. License number D67220		29d. Date signed (Month, Day, Year) 08/29/2011			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ADEEL ABBAS, MD - 2833 SMITH AVE. #203, BALTIMORE, MD.</b>								
31. Date filed (Month, Day, Year) SEP 07 2011		32. Registrar's Signature 						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28359

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

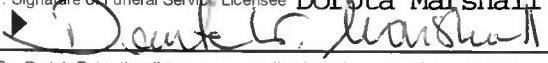
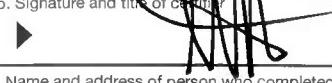
To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)		Ching Lin Yang		2. Date of Death	Month	Day	Year	3. Time of Death				
						September	4,	2011	12:00 P M					
4a. Facility Name (if not institution, give street and number)		Potomac Valley Nursing Home		4b. City, Town, or Location of Death		Rockville		4c. County of Death		Montgomery				
5. Social Security Number		6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)							
220-29-0282		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	92 Yrs.	Months	Days	(Month, Day, Year)	09/29/1918		Taiwan					
Usual Residence of Decedent														
10a. State	MD	10b. County	Montgomery		10c. City, Town or Location	Rockville		10d. Inside City Limits						
10e. Street and Number		1235 Potomac Valley Road		10f. Zip Code		20850		10g. Citizen of What Country?						
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: Asian					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:								
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry						
Elementary/Secondary (0-12) 12				College (1-4 or 5+) 5+				Engineer Engineering						
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)									
					unkn. unkn.									
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Elizabeth Brian/Guardian				401 Hungerford Dr., 2nd Floor, Rockville, MD										
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Atlantic Crematory				9/7/2011	Glen Burnie, MD					
21. Signature of Funeral Service Licensee Dorota Marshall				22. Name and Address of Facility										
				Maryland Cremation Services PO Box 1413, Baltimore, MD 21203										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Immediate Cause (Final disease or condition resulting in death)														
23b. Part 2. Enter the underlying cause(s) leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
<p>a. Due to (or as a consequence of): <i>Anemia</i></p> <p>b. Due to (or as a consequence of): <i>Failure to thrive</i></p> <p>c. Due to (or as a consequence of): <i>HIV</i></p> <p>d. Due to (or as a consequence of): <i>Hypertension</i></p>														
Approximate Interval Between Onset and Death														
IF FEMALE:		23c. If yes, outcome of pregnancy		23d. Date of delivery										
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
23e. Did tobacco use contribute to the cause of death?														
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)								
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work?		28d. Describe how injury occurred						
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		M		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier 		MD		29c. License number		D0052574		29d. Date signed (Month, Day, Year)						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Ahmed Moshrefy 1235 Potomac Valley Rd, Rockville, MD												
31. Date filed (Month, Day, Year)		SEP 07 2011		32. Registrar's Signature										

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

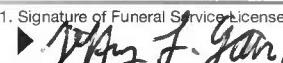
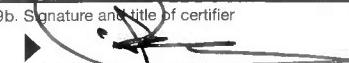
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28360

1 - For State Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Leslie Ellen Zowada</b>					2. Date of Death Month <b>September</b> Day <b>02</b> , Year <b>2011</b>	3. Time of Death <b>8:55 P.M.</b>		
	4a. Facility Name (if not institution, give street and number) <b>Gilchrist Hospice Center</b>					4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>	
<b>Funeral Director</b>	5. Social Security Number <b>047-60-3702</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months      Days	If Under 24 Hrs. Hours      Min.	8. Date of Birth (Month, Day, Year) <b>May 20, 1959</b>	9. Birthplace (State or Foreign Country) <b>Manchester, CT.</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b> 10b. County <b>Baltimore County</b> 10c. City, Town or Location <b>Towson</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>7 Acorn Circle Apt. 301</b>					10f. Zip Code <b>21286</b>	10g. Citizen of What Country? <b>United States of America</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Marketing Management</b>			16b. Kind of Business/Industry <b>Marketing</b>		
	17. Father's Name (First, Middle, Last) <b>Raymond J. Zowada</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Graeser</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>(Mother)</b> <b>Mrs. Margaret G. Schaffer</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 Meadowcroft Lane Lutherville, Maryland 21093</b>					
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel and Cremation Services, Inc.</b>		Date <b>Saturday, Sept. 03, 2011</b>	20c. Location - City or Town, State <b>(Harford County) Forest Hill, Maryland</b>		
	21. Signature of Funeral Service Licensee  <b>Jeffrey L. Gair, Sr. OFP</b> Lic. #M00677			22. Name and Address of Facility <b>Peaceful Alternatives Funeral and Cremation Center, P.A.</b> <b>235 York Road Timonium, Maryland 21093-2215</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): <b>Colon Cancer</b>							Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier  <b>M.D.</b>			29c. License number <b>D0071287</b>			29d. Date signed (Month, Day, Year) <b>9-3-11</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204</b>								
	31. Date filed (Month, Day, Year) <b>SEP 07 2011</b>		32. Registrar's Signature <b>Anna S. Farak</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3  
State Registrar

## Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
 Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #14 Per FH G919 9/29/2011 JB

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28361

1 - For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month: September Day: 03 Year: 2011		3. Time of Death 20:35 PM
Deborah Zuber				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
The Johns Hopkins Hospital				
5. Social Security Number 193-52-7843		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	8. Date of Birth (Month, Day, Year) May 3, 1959
9. Usual Residence of Decedent PA Berks		10c. City, Town or Location Blandon		10d. Inside City Limits <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 413 Chestnut Street		10f. Zip Code 19510		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16b. Kind of Business Industry Mailing
17. Father's Name (First, Middle, Last) Henry Arthur Lorah		18. Mother's Name (First, Middle, Maiden Surname) Rosealene Jean Kocher		
19a. Informant's Name/Relationship (Type, Print) Kenneth Lee Zuber/		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Chestnut Street Blandon, PA 19510		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Evans Crematory		20c. Location - City or Town, State Reading, PA
21. Signature of Funeral Service Licensee Gray Harris		22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): Asystole				
b. Due to (or as a consequence of): Pulmonary Embolus				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Charity Gray		29c. License number RES-060		29d. Date signed (Month, Day, Year) September 3, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charity Gray		31. Date filed (Month, Day, Year) SEP 07 2011		
		32. Registrar's Signature Susan J. Parker		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28362

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Alexandria Ziolkowski	September 4, 2011	12:35 A M

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1309 Sheridan Place	Bel Air	Harford

5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 13, 1939	9. Birthplace (State or Foreign County) Maryland
219-26-5582		72			

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Harford	Bel Air	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1309 Sheridan Place	21015	USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker	16b. Kind of Business Industry Own Home
--	--	--

17. Father's Name (First, Middle, Last) Alexander (nnn) Klosek	18. Mother's Name (First, Middle, Maiden Surname) Bessie (nnn) Wagner
---	--

19a. Informant's Name/Relationship (Type, Print) Eric Ziolkowski / Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Mt. Wilson Lane, Pikesville, Maryland 21208
---	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Hilltop Service Corp.	20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.	Date 9-7-2011	20c. Location - City or Town, State Towson, Maryland
---	--	------------------	---

21. Signature of Funeral Service Licensee ► Stephen A. Deagle	22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009
--	---

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death FIVE MINUTES
a. Due to (or as a consequence of): VENTRICULAR FIBRILLATION	
b. Due to (or as a consequence of): ATRIAL FIBRILLATION	18 months
c. Due to (or as a consequence of): PULMONARY HYPERTENSION	FOUR YEARS
d. Due to (or as a consequence of): RHEUMATIC HEART DISEASE	THIRTY YEARS

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
CHRONIC KIDNEY DISEASE SYSTEMIC HYPERTENSION	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier ► Jonathan Safran MD	29c. License number MARYLAND D0041711	29d. Date signed (Month, Day, Year) September 6, 2011
---	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN SAFREN MD 3449 WILKENS AVENUE SUITE 300 BALTIMORE, MARYLAND 21042
--

31. Date filed (Month, Year) 09/07/2011	32. Registrar's Signature Anna J. Safran
---	---

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

To the Physician/Medical Examiner: The law requires that the death certificate be executed

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician.

page 2 should be detached for use as the burial-transit

within 24 hours after death.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

any injury or other traumatic event, the Medical Examiner must be notified at

once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

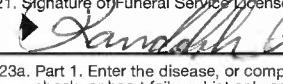
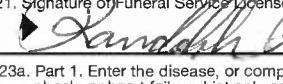
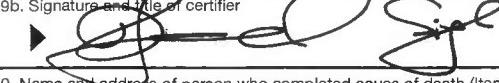
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28363

For  
State  
Registrar

**Physician/  
Medical  
Examiner**

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Damion Elmar Anderson</b>				2. Date of Death Month <b>August</b> Day <b>15</b> , Year <b>2011</b>		3. Time of Death 07:12 A.M.	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director		5. Social Security Number <b>214-25-8436</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>29</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>January 13, 1982</b>		9. Birthplace (State or Foreign Country) <b>Kingston, Jamaica</b>
To Be Completed by Funeral Director		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Adelphi</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>10414 Deakins Hall Drive</b>				10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>United States</b>	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>None</b>		16b. Kind of Business Industry <b>None</b>	
		17. Father's Name (First, Middle, Last) <b>Carlton Anderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Ione Bowen</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Josephine Ione Allen (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10414 Deakins Hall Drive; Adelphi, Maryland 20783</b>			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bowen Family Cemetery</b>		Date <b>August 27, 2011</b>	20c. Location - City or Town, State <b>Westmoreland, Jamaica, West Indies</b>
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011</b>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				<i>Gastric Carcinoma with Metastasis</i>		Approximate Interval Between Onset and Death	
		<p>a. Due to (or as a consequence of): </p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DY5660</b>				29d. Date signed (Month, Day, Year) <b>8-15-11</b>	
		29b. Signature and title of certifier 							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>14300, GALLANT Fox Ln, 124 Bowie MD 20715</b>							
		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28364

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
Loretta Virginia Anderson		August 13 2011				11:44 AM		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
Peninsula Regional medical center		Salisbury		Wicomico				
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 06/12/1938	9. Birthplace (State or Foreign Country) Maryland	
217-36-2245								
Usual Residence of Decedent								
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Maryland	Wicomico	Salisbury						
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
7576 Hogans Lane			21801			United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12) 10		College (1-4 or 5+)		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business Industry Own Home
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
Robert Benjamin Creighton, Sr.				Alva Virginia Parks				
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Donne Anderson / Husband		7576 Hogans Lane, Salisbury, MD 21801						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
		Eastern Shore Veterans Cem.		08/22/2011	Hurlock, Maryland			
21. Signature of Funeral Service Licensee <i>Michael Kevin Anderson, Jr.</i>		22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular Accident</i>								
Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Due to (or as a consequence of): <i>A. Fibillation</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier <i>Yogesh Vohra</i>		29c. License number D63199		29d. Date signed (Month, Day, Year) 8/13/11				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yogesh Vohra 100 E. Carroll St. Salisbury, Md. 21801								
31. Date filed (Month, Day, Year) AUG 15 2011		32. Registrar's Signature <i>James A. Parker</i>						

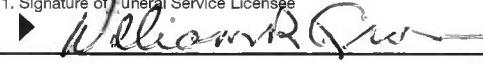
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 28365  
Certificate of Death

1- For State Registrar

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lorna Diane Adair</b>							2. Date of Death Month Day Year <b>August 8 2011</b>	3. Time of Death 3:00 PM
	4a. Facility Name (if not institution, give street and number) <b>7003 Prout Road</b>			4b. City, Town, or Location of Death <b>Friendship</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>213-54-7786</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11-29-1933</b>	9. Birthplace (State or Foreign Country) <b>Canada</b>	
	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Friendship</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>7003 Prout Road</b>			10f. Zip Code <b>20758</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify:
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>2</b> <b>Treasurer</b>			16b. Kind of Business Industry <b>Building Supply, Concrete, Const. Co.</b>		
	17. Father's Name (First, Middle, Last) <b>Albert Thomas Kidd</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Burns</b>			19a. Informant's Name/Relationship (Type, Print) <b>Glenn Adair, Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28460 Highway 72, Golden, CO 80403</b>
Medical Certificate: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			Date <b>8/15/2011</b>	20c. Location - City or Town, State <b>Alexandria, VA</b>	
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility <b>Rausch Funeral Home, P.A.</b>			23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>		
23a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____						Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>MD</b>		28b. Time of injury <b>M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, Maryland 21215-0036</b>							
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>065272</b>			29d. Date signed (Month, Day, Year) <b>8/14/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jason Taksy 2003 Medical Plaza Suite 210 Annapolis MD 21401</b>		32. Registrar's Signature <b>Barbara B. Powell</b>			31. Date filed (Month, Day, Year) <b>AUG 10 2011</b>				

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

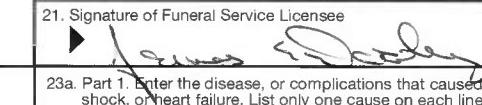
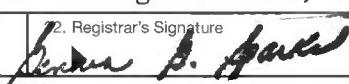
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28366

Reg. No.

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Lisseth N. Argueta</b>						2. Date of Death Month <b>August</b> Day <b>16</b> , Year <b>2011</b>		3. Time of Death <b>1:20 pM</b>	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>10803 Lombardy Road</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director		5. Social Security Number <b>218-73-7554</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>5</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Oct. 22, 2005</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>						10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number <b>10803 Lombardy Road</b>			10f. Zip Code <b>20901</b>			10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Salvadorean</b>			14. Race - American Indian, Black, White, etc. <b>White</b> Specify:		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) None			16b. Kind of Business Industry <b>N/A</b>				
		17. Father's Name (First, Middle, Last) <b>David A. Argueta</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Morena del Carmen Melgares</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>-Mother</b> <b>Morena del Carmen Argueta</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10803 Lombardy Road, Silver Spring, MD 20901</b>			Date <b>Aug. 20 2011</b>			20c. Location - City or Town, State <b>Silver Spring, MD</b>	
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Cate of Heaven Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)							
Physician/ Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc.</b> <b>500 University Blvd. W., Silver Spring, MD 20901</b>							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Brainstem Compression</b>						Approximate Interval Between Onset and Death			
		b. Due to (or as a consequence of): <b>Progressive Diffuse Intrinsic Pontine Glioma</b>						<b>1 yr</b>			
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0055584</b>			29d. Date signed (Month, Day, Year) <b>08/17/2011</b>				
		29b. Signature and title of certifier 									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Brian Rood, MD 111 Michigan Avenue, NW, Washington,</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 							

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28367

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carmen T. H. Aguilera</b>							2. Date of Death Month <b>August</b> Day <b>16</b> , 2011 Year	3. Time of Death <b>11:51 p.m.</b>	
	4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>577-62-4798</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>April 24, 1944</b>	9. Birthplace (State or Foreign Country) <b>Mexico</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>1200 Briggs Chaney Road</b>				10f. Zip Code <b>20905</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
Physician/ Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>2</b> <b>Teacher Assistant</b>		16b. Kind of Business Industry <b>Education</b>					
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Francisco Hernandez</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sirenia Olivares</b>					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Agustin Aguilera - Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1200 Briggs Chaney Road, Silver Spring, MD 20905</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		Date <b>08/23/2011</b>	20c. Location - City or Town, State <b>Silver Spring, MD</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MO1524</b>									
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>M. Aguilera MO1524</b>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b> <b>11800 New Hampshire Ave., Silver Spring, MD 20904</b>							
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b>								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>Myocardial Infarction</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Disease, Diabetes, Hypertension, Cerebral Vascular Accident, High Cholesterol</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Physician/ Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
Medical Certificate: To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>Natural</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
Physician/ Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Lisa Ng, M.D.</b>		29c. License number <b>D0055931</b>		29d. Date signed (Month, Day, Year) <b>August 17, 2011</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lisa Ng, M.D., 4000 Olney-Laytonsville Road, Olney, Maryland 20832</b>								31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>	32. Registrar's Signature <b>Susan J. Garcia</b>

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any time.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28368

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELEANOR MARIE ALEXANDER</b>				2. Date of Death Month AUGUST Day 23 Year 2011	3. Time of Death 10:30PM <sup>M</sup>		
	4a. Facility Name (if not institution, give street and number) <b>576 WEST OLD PHILADELPHIA ROAD</b>		4b. City, Town, or Location of Death <b>NORTH EAST</b>		4c. County of Death <b>CECIL</b>			
Funeral Director	5. Social Security Number <b>214-24-1829</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 16, 1927</b>	9. Birthplace (State or Foreign) <b>HONEY BROOK PENNSYLVANIA</b>	
	Usual Residence of Decedent <b>MARYLAND CECIL</b>		10a. State <b>MARYLAND</b> 10b. County <b>CECIL</b> 10c. City, Town or Location <b>NORTH EAST</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>576 WEST OLD PHILADELPHIA ROAD</b>		10f. Zip Code <b>21901</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>XX</b>	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPING SERVICES</b>			16b. Kind of Business Industry <b>MANUFACTURING</b>		
	17. Father's Name (First, Middle, Last) <b>EDGAR C. MILLER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH BLANCHE GRIFFITH</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>BETTY MARSHALL / DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>43 ARRANTS ROAD, NORTH EAST, MARYLAND 21901</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, cemetery, mortuary, workplace) <b>NORTH EAST CEMETERY METHODIST CEMETERY</b>		Date <b>AUGUST 27, 2011</b>	20c. Location - City or Town, State <b>NORTH EAST, MARYLAND</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901</b>					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>End stage dementia</b>							Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): <b>HTN, Cerebrovascular accident</b>							
	b. Due to (or as a consequence of): <b>Type 2 diabetes</b>							
	c. Due to (or as a consequence of): <b>Hyperlipidemia</b>							
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Mr Sachdev.</b>		29c. License number <b>D0026183</b>		29d. Date signed (Month, Day, Year) <b>8/24/11</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MADHU SACHDEV 322 E CECIL AVE North East, MD 21901</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>08-24-2011 AUG 25 2011</b>		32. Doctor's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 5, per fh, g921 11-18-11 sm

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 28b per me, g919, 09/09/2011 dhp Certificate of Death

Reg. No. 2011 28369

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Shrikrishna G. Athavale</b>										2. Date of Death Month <b>Aug</b> Day <b>16</b> Year <b>2011</b>		3. Time of Death <b>1723 M</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Schuban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>089-48-2719</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87 Yrs.</b>		If Under 1 Year Months      Days		If Under 24 Hrs. Hours      Min.		8. Date of Birth (Month, Day, Year) <b>June 6, 1924</b>		9. Birthplace (State or Foreign Country) <b>Velapur, India</b>	
To Be Completed by Physician/Medical Examiner		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>11801 Rockville Pike, #1704</b>								10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>Elementary/Secondary (0-12)</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify: <b>Structural Engineer</b>				14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Structural Engineer</b>				16b. Kind of Business/Industry <b>Engineering</b>					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Gangadhar Athavale</b>								18. Mother's Name (First, Middle, Maiden Surname) <b>Uma Bhave'</b>					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Vasanti Athavale- wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11801 Rockville Pike, #1704, Rockville, MD 20852</b>									
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Mgh 101234</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>				Date <b>August 18, 2011</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>► Mgh 101234</b>				22. Name and Address of Facility <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</b>									
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>spinal cord injury</b> Due to (or as a consequence of): <b>cervical spine -C2 - fracture</b> minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>fall</b> Due to (or as a consequence of): <b>fall</b> seconds												Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month <b>8</b> Day <b>17</b> Year <b>2011</b>							
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>fall</b>				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>8/16/11</b>		28b. Time of injury <b>Unknown</b> M		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>fall</b>			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>11801 Rockville Pike, #1704 Rockville, MD 20852</b>									
To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>MD 68374</b>				29d. Date signed (Month, Day, Year) <b>8/17/11</b>					
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald Shields, MD, PhD 1215 Fernwood Road Bethesda, MD 20817</b>													
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>				32. Registrar's Signature <b>Denise B. Parker</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28370

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lorraine Delores Bailey</b>							2. Date of Death Month <b>August</b> Day <b>19</b> , Year <b>2011</b>			3. Time of Death <b>3:16A M</b>	
	4a. Facility Name (if not institution, give street and number) <b>Southern Maryland Hospital</b>							4b. City, Town, or Location of Death <b>Clinton</b>			4c. County of Death <b>Prince George</b>	
Funeral Director	5. Social Security Number <b>222-16-2311</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 26, 1930</b>	9. Birthplace (State or Foreign Country) <b>Delaware</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George</b> 10c. City, Town or Location <b>Oxon Hill</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
	10e. Street and Number <b>5802 Birchwood Court</b>				10f. Zip Code <b>20745</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Secretary</b>		16b. Kind of Business Industry <b>D.C. School System</b>							
	17. Father's Name (First, Middle, Last) <b>James Coleman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Hill</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Alexander Bailey, Jr./Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5802 Birchwood Court, Oxon Hill, MD 20745</b>							
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gracelawn Mem'l Park</b>		Date <b>8/23/2011</b>	20c. Location - City or Town, State <b>New Castle, DE</b>						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>George P. Kalas</b>		22. Name and Address of Facility <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ALTEROSCLEROTIC CARDIOVASCULAR DISEASE 90%</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____											
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC KIDNEY DISEASE ON HEMODIALYSIS</b>											
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> COA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide							
	28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier <b>P. COISICK, MD</b>		29c. License number <b>D 18545</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 19, 2011</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. COISICK, MD, 12070 OLD LINE CENTER WALKER, MD 20602</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>J. Parker</b>									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28371

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

1. Decedent's Name (First, Middle, Last) <b>Richard Solon Brown</b>				2. Date of Death Month <b>08</b> Day <b>12</b> Year <b>2011</b>			3. Time of Death <b>5:00 P M</b>
4a. Facility Name (if not institution, give street and number) <b>Hawrel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Hawrel</b>			4c. County of Death <b>Prince Georges</b>
5. Social Security Number <b>238 48 5295</b>		6. Sex <b>M</b>	7. Age (in yrs. last birthday) <b>75 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>AUG 7 1936</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>
Usual Residence of Decedent 10a. State <b>N.C.</b> 10b. County <b>DUPLIN</b> 10c. City, Town or Location <b>ROSE HILL</b> 10d. Inside City Limits <b>1 Yes 2 No</b>							
10e. Street and Number <b>258 EAST CHARITY ROAD</b>				10f. Zip Code <b>28458</b>			10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CEMENT FINISHER</b>		16b. Kind of Business Industry <b>CONSTRUCTION</b>			
17. Father's Name (First, Middle, Last) <b>ROBERT SOLON BROWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE MARIE JONES</b>			
19a. Informant's Name/Relationship (Type, Print) <b>RICHARD D BROWN/ SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>194 CLINIC CIRCLE DR. ROSE HILL NC. 28458</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of Cemetery, cemetery or other place) <b>NEW CHRISTIAN CHAPEL CEMETERY</b>			Date <b>8/19/11</b>	20c. Location - City or Town, State <b>ROSE HILL N.C. 20010</b>	
21. Signature of Funeral Service Licensee <b>Al D. Watson</b>				22. Name and Address of Facility <b>WATSON FH 3435 14th ST. NW WASH. DC</b>			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>Metastatic Pancreatic Cancer</b>								Approximate Interval Between Onset and Death		
<b>a.</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> _____										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown</b>				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Liver metastasis, jaundice, malignant Asbesto Pancytopenia, liver failure</b>								23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>				
27. Manner of Death <b>1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								29c. License number <b>068782</b>		29d. Date signed (Month, Day, Year) <b>08.12.2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Adedegi Kawanwi MD</b>										
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature <b>James B. Parker</b>								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28372

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

1. Decedent's Name (First, Middle, Last)		Josephine Lee Beynon		2. Date of Death	Month 8 Day 9 Year 2011	3. Time of Death	0822 M
4a. Facility Name (if not institution, give street and number)		WMHS-RMC		4b. City, Town, or Location of Death		Cumberland	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	
196-18-0297		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	86 Yrs.	Months	Days	Hours	Min.
9. Usual Residence of Decedent		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland	
10d. Inside City Limits		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number		11. Marital Status		10f. Zip Code		10g. Citizen of What Country?	
1 Baltimore Street Apt. 102		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		21502		USA	
12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Director of Tourism		Allegany County			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Augustus Darrah		Martha Brooks					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Donald Beynon Jr. son		1129 Pennsylvania Ave. Oakmont PA 15139					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Sunset Memorial Park		8/13/2011	Cumberland MD		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility					
		Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23c. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23d. Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  <i>Sepsis</i>		b. Due to (or as a consequence of):  <i>Ventricular Tachycardia</i>		c. Due to (or as a consequence of):  <i>Dehydration</i>	
						d. Due to (or as a consequence of):  <i>Incarcerated Ventral hernia</i>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No g <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Renal Failure on Dialysis</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
24. Place of Death (Check only one)		25. Manner of Death		26. Place of Death (Check only one)			
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
M		M		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Bickel MD		29c. License number DO061406			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) AUG 10 2011		32. Registrar's Signature 		29d. Date signed (Month, Day, Year) 08-09-2011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #23e Per PHY G919 9/07/2011 JH  
State of Maryland Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2011 28373

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SARAH MICHELLE BUCKINGHAM</b>						2. Date of Death Month AUGUST Day 9 Year 2011	3. Time of Death 12:30 PM		
	4a. Facility Name (if not institution, give street and number) <b>96 N. RIVERTON RD</b>			4b. City, Town, or Location of Death <b>ELKTON</b>			4c. County of Death <b>CECIL</b>			
Funeral Director	5. Social Security Number <b>495-82-3035</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>31</b> Yrs.	If Under 1 Year Months      Days	If Under 24 Hrs. Hours      Min.	8. Date of Birth (Month, Day, Year) <b>1/30/1980</b>	9. Birthplace (State or Foreign Country) <b>MISSOURI</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>CECIL</b>	10c. City, Town or Location <b>ELKTON</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>96 N. RIVERTON RD</b>			10f. Zip Code <b>21921</b>			10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEDICAL CLERK</b>			16b. Kind of Business/Industry <b>HOSPITAL</b>			
	17. Father's Name (First, Middle, Last) <b>MICHAEL R. REISING</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>TAMELA POPE</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ERIC J. BUCKINGHAM/HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>96 N. RIVERTON RD ELKTON, MD 21921</b>					
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETHEL CEMETERY</b>			Date <b>8/13/2011</b>	20c. Location - City or Town, State <b>CHESAPEAKE CITY, MD</b>			
	21. Signature of Funeral Service Licensee <i>Deborah Meyer</i>		22. Name and Address of Facility <b>SPICER-MULLIKIN FH</b> <b>1000 N DUPONT PKY NEW CASTLE, DE 19720</b>							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>Malignant Melanoma</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 		29c. License number <b>D0062190</b>			29d. Date signed (Month, Day, Year) <b>8/10/2011</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAHNAWAZ KHAN, 2533 AUGUSTINE HERMAN Hwy, SUITE A, CHESAPEAKE CITY, MD 21915</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28374

1 - For  
State  
Register

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Theresa Elizabeth Burns</b>							2. Date of Death Month <b>08</b> Day <b>17</b> Year <b>2011</b>	3. Time of Death <b>8:50 PM</b>
4a. Facility Name (if not institution, give street and number) <b>Larkin Chase Nursing and Restorative</b>							4b. City, Town, or Location of Death <b>Bowie</b>	4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>578-76-2256</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <b>07/19/1923</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>		
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Bowie</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>15005 Health Center Drive</b>			10f. Zip Code <b>20716</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>Elementary/Secondary (0-12) 0</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Child Care</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+) 0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Child Care</b>			16b. Kind of Business Industry <b>Domestic</b>			
17. Father's Name (First, Middle, Last) <b>Sylvester Emmet Burns</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Helen Muir</b>				
19a. Informant's Name/Relationship (Type, Print) <b>John Jarboe- Nephew</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6430 Weems Ave, Tracys Landing, MD 20779</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mt. Olivet Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>Aug. 23, 2011</b>	20c. Location - City or Town, State <b>Washington DC</b>		
21. Signature of Funeral Service Licensee <b>Amanda M. Ergler</b>			22. Name and Address of Facility <b>Lee Funeral Home Calvert P.A. 8200 Jennifer Lane, Owings, MD 20736</b>					

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>Cardiac amyloidosis</b>			Approximate Interval Between Onset and Death	
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p><b>{</b></p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Faile to thrive</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <b>J</b>		29c. License number <b>D57028</b>			29d. Date signed (Month, Day, Year) <b>August 18, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aditya Chopra MD 600 Ridgely Ave Ste 231 Annapolis MD 21401</b>						
31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature <b>J. Burns</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28375

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Joe Bollo, Jr.</b>							2. Date of Death Month <b>08</b> Day <b>15</b> Year <b>2011</b>	3. Time of Death 06:20 AM
4a. Facility Name (if not institution, give street and number) <b>Ammahl Home Assisted Living</b>				4b. City, Town, or Location of Death <b>Olney</b>			4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>228-07-0445</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>03/28/1918</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>Chesapeake Beach</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
10e. Street and Number <b>3080 Cox Road</b>				10f. Zip Code <b>20732</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>6</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sheet Metal Worker</b>			16b. Kind of Business Industry <b>Local 100</b>	
17. Father's Name (First, Middle, Last) <b>Joe Bollo, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Tomi</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Michael Bollo/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3080 Cox Road, Chesapeake Beach, MD 20732</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Lisa M. Mounts</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>			Date <b>08/16/2011</b>	20c. Location - City or Town, State <b>Clinton, MD</b>	
21. Signature of Funeral Service Licensee <b>Lisa M. Mounts</b>				22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736</b>				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Right Insufficiency</b>		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): <i>Arteriole Calcification</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Right Insufficiency</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Assisted Living</b>		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At R.W.W., MD</b>		28f. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>1908381</b>		
29b. Signature and title of certifier <b>Benjamin Arvin, MD</b>		29d. Date signed (Month, Day, Year) <b>August 15, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Benjamin Arvin, MD</b>		31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		
32. Registrar's Signature <b>James D. Parker</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28376

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Goldie Burrell  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Min PM
Goldie J. Burrell		August 10 2011		11:50 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Baltimore Washington Medical Center		Glen Burnie		Anne Arundel
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min.
214-46-0069				
8. Date of Birth (Month, Day, Year) May 14 1945		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent				
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Annapolis		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 11 College Creek Terrace		10f. Zip Code 21401		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business Industry Clothing Store
17. Father's Name (First, Middle, Last) Carl E. Burrell		18. Mother's Name (First, Middle, Maiden Surname) Perdella Smith		
19a. Informant's Name/Relationship (Type, Print) Janice Sewell (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8202 Kramer Ct. Apt 2D Glen Burnie, Md. 21061		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Memorial Gardens	Date 8-19-11	20c. Location - City or Town, State Annapolis, Md.
21. Signature of Funeral Service Licensee Larry H. Reese		Name and address of Facility The Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 2yr		
<p>a. Due to (or as a consequence of): Emphysema</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV Sleep Apnea		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Goldie J. Burrell		
		29c. License number 132036		29d. Date signed (Month, Day, Year) 8/11/2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goldie J. Burrell		31. Date filed (Month, Day, Year) AUG 17 2011		
		32. Registrar's Signature Anna P. Parker		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28377

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Mae Thelma Butler</b>				2. Date of Death Month Day Year <b>August 14, 2011</b>	3. Time of Death 3:32 P M		
	4a. Facility Name (if not institution, give street and number) <b>Southern Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>			
<b>Funeral Director</b>	5. Social Security Number <b>578-44-4446</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>93 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 13, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Clinton</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>7400 Berkshire Drive</b>			10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aide</b>			16b. Kind of Business Industry <b>Healthcare</b>	
	17. Father's Name (First, Middle, Last) <b>Wordie E. Savoy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary V. Proctor</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ray A. Butler / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7017 Allentown Road Temple Hills, Maryland 20748</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		Date <b>08/19/2011</b>	20c. Location - City or Town, State <b>Clinton, Maryland</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745</b>				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Cardiovascular Disease</b>							Approximate Interval Between Onset and Death <b>5 years</b>
	b. <b>Pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							3 days
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>045365</b>		29d. Date signed (Month, Day, Year) <b>08-15-2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. Sidman, M.D. 11701 Livingston Rd #101, Ft Washington MD 20748</b>		31. Date filed (Month, Day, Year) <b>AUG 17 2011</b> 32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

Within 24 hours after death.  
Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28378

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1446 hrs
ALAN AMES BOOTY	August 23, 2011	

**Funeral Director**

4a. Facility Name (if not institution, give street and number) 9 Silverwood Circle, Apt. 11	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
--	---	-------------------------------------

**To Be Completed by Funeral Director**

5. Social Security Number 219-48-4874	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 08/29/1946	9. Birthplace (State or Foreign Country) MARYLAND
--	--	---	---	---	--

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician/  
Medical Examiner**

10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ANNAPOLIS	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
------------------------	-----------------------------	--	--

10e. Street and Number 9 SILVERWOOD CIRCLE, APT. 11	10f. Zip Code 21403	10g. Citizen of What Country? USA
--	------------------------	--------------------------------------

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: If Yes, Give Year of Dates: 1966-1972	14. Race - American Indian, Black, White, etc. Specify: WHITE
--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry 2 PRE-SALES BUSINESS MANAGER COMMUNICATIONS
--	--	---

17. Father's Name (First, Middle, Last) AMOS BOOTY	18. Mother's Name (First, Middle, Maiden Surname) MARGARET MATTHEWS
---	--

19a. Informant's Name/Relationship (Type, Print) MICHELLE DEMERS/DAUGHTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11870 SUGAR HILL RD, DAVIDSON, NC 28036
--	--

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE VETERANS CEMETERY	Date 08/30/2011	20c. Location - City or Town, State CROWNSVILLE, MD
--	---	--------------------	--

21. Signature of Funeral Service Licensee	22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELPENBEIN & NEWMAN CREMATION & FUNERAL CARE, P.A. 814 BESTGATE ROAD, ANNAPOLIS, MD 21401
---	--

23a. Part I. Enter the disease, condition, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
--	--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
--	--	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g919 9-9-11 sm	
--	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

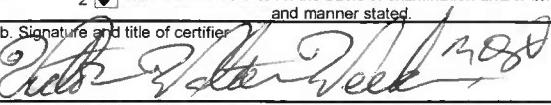
**Chronic obstructive pulmonary disease**

<b>Diabetes</b>	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
-----------------	---	--

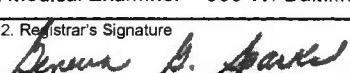
<b>Chronic Alcohol Use</b>	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
---	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 24, 2011
--	--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) AUG 29 2011	32. Registrar's Signature 
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

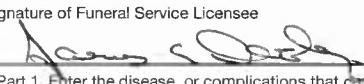
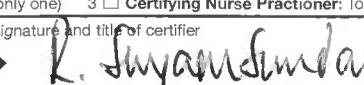
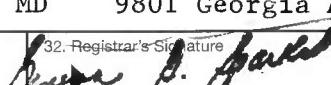
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28379

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death 5:00 PM								
	Guy Thomas Brunetto							August 16, 2011									
Funeral Director	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death									
	Bedford Court Nursing Home			Silver Spring				Montgomery									
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) Sept. 1, 1917	9. Birthplace (State or Foreign Country) PA								
Usual Residence of Decedent																	
10a. State MD	10b. County Montgomery	10c. City, Town or Location Silver Spring							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 3701 International Drive				10f. Zip Code 20906				10g. Citizen of What Country? USA									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder			16b. Kind of Business Industry Medical											
17. Father's Name (First, Middle, Last) Nunziato Brunetto					18. Mother's Name (First, Middle, Maiden Surname) Anna Ranieri												
19a. Informant's Name/Relationship (Type, Print) Gaetan N. Brunetto/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8505 Cherrymeadow Court, Derwood, MD 20855														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date Aug. 19 2011	20c. Location - City or Town, State Silver Spring, MD										
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901														
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
Immediate Cause (Final disease or condition resulting in death) Metastatic Bone and Lung Disease																	
Approximate Interval Between Onset and Death Months																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																	
<table border="1"> <tr> <td>a. Metastatic Bone and Lung Disease Due to (or as a consequence of): Possible Lung Cancer</td> <td>1 year</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>										a. Metastatic Bone and Lung Disease Due to (or as a consequence of): Possible Lung Cancer	1 year	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
a. Metastatic Bone and Lung Disease Due to (or as a consequence of): Possible Lung Cancer	1 year																
b. Due to (or as a consequence of):																	
c. Due to (or as a consequence of):																	
d. Due to (or as a consequence of):																	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
Depression, Failure to Thrive, Cachexia																	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier 		29c. License number D53367				29d. Date signed (Month, Day, Year) August 18, 2011											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajan Shyamsundar, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902																	
31. Date filed (Month, Day, Year) AUG 19 2011		32. Registrar's Signature 															

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.

Completed filled in by the funeral director.

DHMH 17 Rev 7/2009

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28380

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 1506 M
<i>Ethel Becker</i>		August 16, 2011		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Holy Cross Hospital</i>		<i>Silver Spring</i>		<i>Montgomery</i>
5. Social Security Number <i>123-28-3135</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>94</i> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) <i>08/23/1916</i>
9. Birthplace (State or Foreign Country) <i>New York</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>
10e. Street and Number <i>922 Brentwood Lane</i>		10f. Zip Code <i>20902</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>white</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Dental Assistant</i>		16b. Kind of Business Industry <i>Healthcare</i>
17. Father's Name (First, Middle, Last) <i>Joseph Dauber</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Winter</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Michael Chelst -grand son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>922 Brentwood Lane, Silver Spring, Maryland 20902</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Katrina Ferguson MIS64</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Har Hazeyton Cem.</i>		Date <i>08/18/2011</i>
21. Signature of Funeral Service Licensee <i>Katrina Ferguson MIS64</i>		22. Name and Address of Facility <i>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death <i>1 Hour</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D09834</i>		
29b. Signature and title of certifier <i>Barry Rosenbaum, M.D.</i>		29d. Date signed (Month, Day, Year) <i>August 16, 2011</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Barry Rosenbaum, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895</i>				
31. Date filed (Month, Day, Year) <i>AUG 18 2011</i>		32. Registrar's Signature <i>Barry Rosenbaum, M.D.</i>		

DANIEL John BAKER

11-06096

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28381

1- For State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Daniel John Baker</i>					2. Date of Death Month Day Year August 13, 2011	3. Time of Death 0030 hrs		
	4a. Facility Name (if not institution, give street and number) 15709 Holly Grove Rd			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery			
<b>Funeral Director</b>	5. Social Security Number 217-11-3584	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 27 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 08/10/1984	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Silver Spring	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number 13642 Cedar Creek Lane			10f. Zip Code 20904		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No specify:	14. Race - American Indian, Black, White, etc. Specify: Caucasian					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Pet Care			
	17. Father's Name (First, Middle, Last) Michael Baker			18. Mother's Name (First, Middle, Maiden Surname) Linda Proulx					
	19a. Informant's Name/Relationship (Type, Print) Linda Baker - Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13642 Cedar Creek Ln., Silver Spring, MD 20904		Date 08/18/2011		20c. Location - City or Town, State Olney, Maryland		
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Grdns		Date 08/18/2011		20c. Location - City or Town, State Olney, Maryland		
	21. Signature of Funeral Service Licensee Michael J. Vella MO1241		22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death		
	<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		26. Place of Death (Check only one)		
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Aug 13, 2011		28b. Time of injury 0022 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Occupant of auto involved in collision
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street						28f. Location (Street and Number or Rural Route Number, City or Town, State) 15709 Holly Grove Rd, Silver Spring, MD		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>J. Titus</i>						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 13, 2011
	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
<b>State Registrar</b>	31. Date filed (Month, Day, Year) AUG 18 2011		32. Registrar's Signature <i>Leanne B. Parker</i>						

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28382

1 For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<i>ROBERT L. BELL</i>		Month <i>08</i>	Day <i>17</i>	Year <i>2011</i>
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Mandrin Hospice House</i>		<i>Harwood</i>		<i>Anne Arundel</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>87</i> Yrs.	If Under 1 Year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. State <i>Pennsylvania</i>		10b. County <i>Chester</i>		8. Date of Birth <i>07/03/1923</i>
10e. Street and Number <i>51 S. 12th Avenue</i>		10f. Zip Code <i>19320</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <i>50-83</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Neurosurgeon</i>		16b. Kind of Business Industry <i>Medicine</i>
17. Father's Name (First, Middle, Last) <i>Samuel L. Bell</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Nellie Fait</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Helen Louise Bell - Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>51 S. 12th Avenue, Coatesville, PA 19320</i>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt Vernon Cemetery</i>		Date <i>8/23/2011</i>
20c. Location - City or Town, State <i>Elizabeth Twp., PA</i>				
21. Signature of Funeral Service Licensee <i>Martin T. McElroy</i>		22. Name and Address of Facility <i>John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <i>days</i>
a. Due to (or as a consequence of): <i>CVA</i>				
b. Due to (or as a consequence of): <i>HTN</i>				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Mandrin Hospice House</i>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred <i>Mandrin Hospice House</i>
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>021438</i>		29d. Date signed (Month, Day, Year) <i>August 18 2011</i>
29b. Signature and title of certifier <i>Michael J. LaPenta</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael J. LaPenta</i>				
31. Date filed (Month, Day, Year) <i>AUG 19 2011</i>		32. Registrar's Signature <i>Renata A. Parker</i>		

EWS  
2/21/11State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28383

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year	3. Time of Death 2141 hrs
Kelvin Bias	August 24, 2011	

**Funeral Director**

4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel			
5. Social Security Number 213-88-9160	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) June 9-1962	9. Birthplace (State or Foreign) Maryland

Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Lothian	

10e. Street and Number 1059 Marlboro Rd.	10f. Zip Code 20711	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year 1991-93	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2yrs	16b. Kind of Business/Industry Contractor
---	---	--

17. Father's Name (First, Middle, Last) Harvey L. Bias Sr	18. Mother's Name (First, Middle, Maiden Surname) Marie Jones
--	--

19a. Informant's Name/Relationship (Type, Print) Patricia Adams Bias (Stepmother)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1059 Marlboro Rd. Lothian, Md. 20711
--	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Veterans	Date 9-6-11	20c. Location - City or Town, State Cheltenham, Md.
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21. Signature of Funeral Service Licensee <i>Karen Reese</i>	22. Name and Address of Facility Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401
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**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Physician /Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. <b>Cardiac tamponade</b> Due to (or as a consequence of):
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Hemopericardium</b> Due to (or as a consequence of):
--	---

	c. <b>Ruptured-type I aortic dissection</b> Due to (or as a consequence of):
--	---

	d. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b>
--	---

<input type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED 23a-d, 27, per me, g919 9-9-11 sm 8, per fh, g919 9-20-11 sm	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---	--

29b. Signature and title of certifier <i>Patricia Aronica-Pollak</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 25, 2011
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30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) AUG 31 2011	32. Registrar's Signature <i>Patricia Aronica-Pollak</i>
--	---

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28384

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mollie Lewis Berch</i>				2. Date of Death Month Day Year <i>August 20, 2011</i>	3. Time of Death 11:10am		
	4a. Facility Name (if not institution, give street and number) <i>Hebrew Home of Greater Washington</i>		4b. City, Town, or Location of Death <i>Rockville</i>		4c. County of Death <i>Montgomery</i>			
Funeral Director	5. Social Security Number <i>577-64-9733</i>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>10/31/1919</i>	9. Birthplace (State or Foreign Country) <i>Washington, DC</i>		
	Usual Residence of Decedent 10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <i>2100 Washington Avenue, Apt. #10B</i>			10f. Zip Code <i>20910</i>	10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <i>College (1-4 or 5+)</i> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Educator</i>		16b. Kind of Business Industry <i>Synagogue</i>			
	17. Father's Name (First, Middle, Last) <i>Moses Lewis</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Bessie Friedman</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Mark Berch - Son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11713 Stonington Place, Silver Spring, MD 20902</i>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>M01524</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Lebanon Cemetery</i>		Date <i>08/22/2011</i>	20c. Location - City or Town, State <i>Adelphi, Maryland</i>		
	21. Signature of Funeral Service Licensee <i>Mark Berch</i>		22. Name and Address of Facility <i>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</i>					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Duodenal cancer</i>						Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <i>Gastric outlet obstruction</i>							
	b. Due to (or as a consequence of): <i>Cardio pulmonary arrest</i>							
	c. Due to (or as a consequence of): d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Nursing Home</i>			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <i>August 20, 2011</i>		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Silver Spring, MD</i>					
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Anil Dose</i>		29c. License number <i>D0066162</i>		29d. Date signed (Month, Day, Year) <i>08-20-2011</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Edith Anil Dose, MD, 1500 Forest Glen Rd., Silver Spring, MD</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>AUG 23 2011</i>		32. Registrar's Signature <i>Debra J. Parker</i>					

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-travel document.

20

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 28385

1 - For  
State  
Registration

AMEND#29aperMD, 8/22/11; BMW, MoCo

## Certificate of Death

Reg. No.

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>George Theodor Brown</b>							2. Date of Death Month <b>August</b> Day <b>13</b> , 2011 Year	3. Time of Death <b>5:55 a.m.</b>		
	4a. Facility Name (if not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>			
<b>Funeral Director</b>	5. Social Security Number <b>215-06-1062</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Aug. 15, 1932</b>	9. Birthplace (State or Foreign Country) <b>Switzerland</b>				
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>				10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5721 Grosvenor Lane</b>				10f. Zip Code <b>20814</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>General Manager</b>			16b. Kind of Business Industry <b>Hotel</b>			
	17. Father's Name (First, Middle, Last) <b>Georges Edmund Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elvira Jeanne Maurice Gendre</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Pia Brown/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>704 10th Street, NE, Washington, DC 20002</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>Aug. 26, 2011</b>	20c. Location - City or Town, State <b>Alexandria, VA</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>						
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
	<p>a. <b>Arteriosclerotic Cardiovascular disease</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D 19085</b>					29d. Date signed (Month, Day, Year) <b>8/13/2011</b>			
	29b. Signature and title of certifier 										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick W. Randolph, MD</b>		30. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>8600 Old Georgetown Road, Bethesda, MD 20814</b>								
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036  
permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2011 28386

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>RUTH MANNING BRITTINGHAM</b>						2. Date of Death Month <b>08</b> Day <b>17</b> Year <b>2011</b>	3. Time of Death <b>6:07 AM</b>
		4a. Facility Name (if not institution, give street and number) <b>Hartley Hall Nursing Home</b>			4b. City, Town, or Location of Death <b>Pocomoke City</b>			4c. County of Death <b>Worcester</b>	
Funeral Director		5. Social Security Number <b>225-56-6654</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>April 23, 1916</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke City</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director		10e. Street and Number <b>1006 Market Street</b>			10f. Zip Code <b>21851</b>			10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>			16b. Kind of Business Industry <b>Education</b>	
		17. Father's Name (First, Middle, Last) <b>James Edward Manning, Jr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Nock</b>				
Physician/ Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Sue B. Bundick</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1409 Linden Drive, Pocomoke City, MD 21851</b>				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Nelson's Cem.</b>			Date <b>8/21/2011</b>	20c. Location - City or Town, State <b>Pocomoke, MD</b>
Physician/ Medical Examiner		21. Signature of Funeral Service Licensee <b>Michael A. Dean</b>			22. Name and Address of Facility <b>Holloway Funeral Home, P.A. 107 Vine Street, Pocomoke City, MD 21851</b>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Approximate Interval Between Onset and Death				
Physician/ Medical Examiner		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Date of delivery Month Day Year				
		<p>a. Due to (or as a consequence of): <b>Coronary Atherosclerosis</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
Physician/ Medical Examiner		23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Physician/ Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
Physician/ Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
Physician/ Medical Examiner		29b. Signature and title of certifier <b>SARAH R. BARAL, MD</b>			29c. License number <b>D54422</b>			29d. Date signed (Month, Day, Year) <b>08-17-2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1604 Market St.; Pocomoke, MD 21851</b>							
Physician/ Medical Examiner		31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>			32. Registrar's Signature <b>Sarah J. Parks</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28387

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Berlinger, Doris J. T.O.D. 0411  
DOD: 7/28/11

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Doris Jean Beringer</b>			2. Date of Death Month 8 Day 19 Year 2011	3. Time of Death 4:11 AM	
4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>			4b. City, Town, or Location of Death <b>Berlin</b>	4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>233-64-8014</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 70	If Under 1 Year Months Days Hours Min.	
				8. Date of Birth (Month, Day, Year) <b>7/28/1941</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
Usual Residence of Decedent 10a. State <b>MD</b>			10b. County <b>Worcester</b>	10c. City, Town or Location <b>Berlin</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>15 East Wind Dr.</b>			10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Office Manager</b>		16b. Kind of Business Industry <b>Texas Instruments</b>	
17. Father's Name (First, Middle, Last) <b>Clarence Austin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Wilma Mayle</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mandy N. Moore / Grand-daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>245 Montrose Ave., Apt. 2 R, Brooklyn, NY 11206</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>First State Crem.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>First State Crem.</b>	Date <b>8/22/2011</b>	20c. Location - City or Town, State <b>Millsboro, DE</b>
21. Signature of Funeral Service Licensee <b>Kim MacLeod</b>			22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <b>Chronic OBSTRUCTIVE Pulmonary Disease</b>		
Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>064585</b>			
29b. Signature and title of certifier <b>Anthony Berling</b>		29d. Date signed (Month, Day, Year) <b>8/19/11</b>			
30. Name and address of person who completed cause of death (Item 2a) (Type, Print) <b>Anthony Berling 9733 LeMoyne Ave Berlin MD 21811</b>					
31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>James S. Parks</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

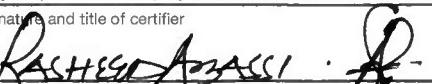
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28388

Reg. No.

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rand Chambers</b>					2. Date of Death Month Day Year <b>August 11, 2011 16:16 M</b>	3. Time of Death
	4a. Facility Name (if not institution, give street and number) <b>Southern Maryland Hospital</b>					4b. City, Town, or Location of Death <b>Clinton</b>	4c. County of Death <b>Prince George's</b>
Funeral Director	5. Social Security Number <b>579-46-9148</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>3/5/1937</b>	9. Birthplace (State or Foreign Country) <b>Raleigh, NC</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Suitland</b>					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>4710 Bromley Ave</b>			10f. Zip Code <b>20746</b>	10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>	16b. Kind of Business Industry <b>Private</b>		
	17. Father's Name (First, Middle, Last) <b>Elker Chambers</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Martin</b>			
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy M. Chambers/ wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4710 Bromley Ave. Suitland, MD 20746</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ft. Lincoln Cemetery</b>			Date <b>8/20/2011</b>	20c. Location - City or Town, State <b>Brentwood, MD</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Johnson &amp; Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011</b>				
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <b>POLYMICROBIAL SEPSIS</b></p> <p>b. Due to (or as a consequence of): <b>GAS GANGRENE WOUND OF LEFT LEG</b></p> <p>c. Due to (or as a consequence of): <b>LARGE BOWEL ISCHEMIA</b></p> <p>d. Due to (or as a consequence of): <b>RESPIRATORY FAILURE</b></p>							
<p>IF FEMALE:</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p>							
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p>							
<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of injury (Month, Day, Year)</p> <p>28b. Time of injury M</p> <p>28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>							
<p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>							
<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number <b>MD 65329</b></p> <p>29d. Date signed (Month, Day, Year) <b>AUGUST 12 2011</b></p>							
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RASHED A. ABASSI 7503 Surratts Road. CLINTON, MD 20735</b></p>							
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>			32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 28389

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Alice Chapman</i>		08 16 2011		0740 AM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>University of Maryland Medical Center</i>		<i>Baltimore</i>		<i>Baltimore</i>
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Nov. 2, 1943</i>
235-68-9302				9. Birthplace (State or Foreign Country) <i>West Virginia</i>
Usual Residence of Decedent				
10a. State <i>MD</i>	10b. County <i>Calvert</i>	10c. City, Town or Location <i>Chesapeake Beach</i>		
10e. Street and Number <i>8084 Silver Fox Way</i>		10f. Zip Code <i>20732</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Seconday (0-12) 12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Office Manager</i>		16b. Kind of Business Industry <i>Private Industry</i>
17. Father's Name (First, Middle, Last) <i>Sid Hatfield</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Mary McCoy</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Sidney Chapman/ Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4050 Robinson Rd., Huntingtown, Md., 20639</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>National Memorial Pk</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>National Memorial Pk</i>		Date <i>8/20/2011</i>
21. Signature of Funeral Service Licensee <i>Craig M01453</i>		22. Name and Address of Facility <i>Everly-Wheatley Funeral Home 1500 W. Braddock Rd., Alexandria, Va., 22302</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i>				
Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): <i>Pneumonia</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>atrial tachycardia</i>				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>NPI 1104051945</i>		
29b. Signature and title of certifier <i>EKA Medical Doctor</i>		29d. Date signed (Month, Day, Year) <i>08/16/2011</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Elizabeth K. Smelter 22 S. Greene Street Baltimore, Maryland 21201</i>				
31. Date filed (Month, Day, Year) <i>AUG 19 2011</i>		32. Registrar's Signature <i>Leanne J. Gault</i>		

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

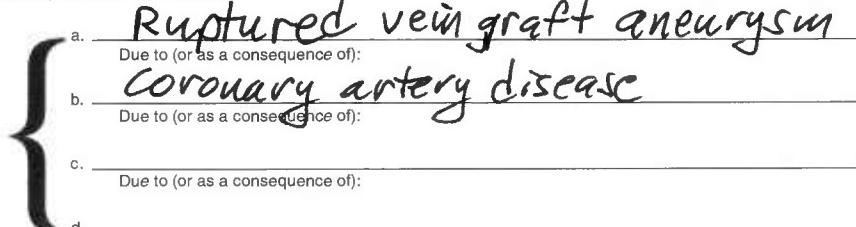
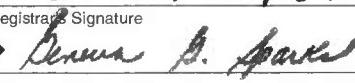
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28390

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles F. Colao					2. Date of Death Month August Day 14, Year 2011	3. Time of Death 4:30 A.M.		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 111-24-2821	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 02/28/1932	9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent 10a. State MD 10b. County Prince George's			10c. City, Town or Location Bowie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 9009 Race Track Road			10f. Zip Code 20715		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) physician			16b. Kind of Business/Industry health care			
	17. Father's Name (First, Middle, Last) Alexander Colao			18. Mother's Name (First, Middle, Maiden Surname) Genevieve unobtainable					
	19a. Informant's Name/Relationship (Type, Print) Varkey Mathew, M.D., POA			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2419 Solomons Island Road, Huntingtown, MD 20639					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 08/17/2011	20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)   a. Due to (or as a consequence of): <i>Ruptured vein graft aneurysm</i> b. Due to (or as a consequence of): <i>Coronary artery disease</i> c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death Years	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 			29c. License number D 36601			29d. Date signed (Month, Day, Year) August 15, 2011		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID M. BRILL MD 7901 Maple Ave., Takoma Park, MD 20912								
	31. Date filed (Month, Day, Year) AUG 17 2011			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 2839 |

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

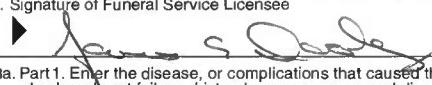
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year <b>August 17, 2011</b>		3. Time of Death 9:30 pM
<b>SUEY Ying chin</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
4a. Facility Name (If not institution, give street and number) <b>Arcola Health &amp; Rehab. Center</b>		5. Social Security Number <b>578-46-6383</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) <b>98 Yrs.</b>
				If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>March 22, 1913</b>
Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Montgomery</b>
10c. City, Town or Location <b>Silver Spring</b>		10e. Street and Number <b>901 Arcola Avenue</b>		10f. Zip Code <b>20902</b>
10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Asian</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Laundromat Owner</b>		16b. Kind of Business/Industry <b>Laundry</b>
17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Moy Unknown</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lon Chin/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5210 17th Street N, Arlington, VA 22205</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery</b>		Date <b>Aug. 23 2011</b>
20c. Location - City or Town, State <b>Adelphi, MD</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Pneumonia</b>		
<b>a.</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  <b>e.</b> Due to (or as a consequence of):  <b>f.</b> Due to (or as a consequence of):  <b>g.</b> Due to (or as a consequence of):  <b>h.</b> Due to (or as a consequence of):  <b>i.</b> Due to (or as a consequence of):  <b>j.</b> Due to (or as a consequence of):  <b>k.</b> Due to (or as a consequence of):  <b>l.</b> Due to (or as a consequence of):  <b>m.</b> Due to (or as a consequence of):  <b>n.</b> Due to (or as a consequence of):  <b>o.</b> Due to (or as a consequence of):  <b>p.</b> Due to (or as a consequence of):  <b>q.</b> Due to (or as a consequence of):  <b>r.</b> Due to (or as a consequence of):  <b>s.</b> Due to (or as a consequence of):  <b>t.</b> Due to (or as a consequence of):  <b>u.</b> Due to (or as a consequence of):  <b>v.</b> Due to (or as a consequence of):  <b>w.</b> Due to (or as a consequence of):  <b>x.</b> Due to (or as a consequence of):  <b>y.</b> Due to (or as a consequence of):  <b>z.</b> Due to (or as a consequence of):  <b>aa.</b> Due to (or as a consequence of):  <b>bb.</b> Due to (or as a consequence of):  <b>cc.</b> Due to (or as a consequence of):  <b>dd.</b> Due to (or as a consequence of):  <b>ee.</b> Due to (or as a consequence of):  <b>ff.</b> Due to (or as a consequence of):  <b>gg.</b> Due to (or as a consequence of):  <b>hh.</b> Due to (or as a consequence of):  <b>ii.</b> Due to (or as a consequence of):  <b>jj.</b> Due to (or as a consequence of):  <b>kk.</b> Due to (or as a consequence of):  <b>ll.</b> Due to (or as a consequence of):  <b>mm.</b> Due to (or as a consequence of):  <b>nn.</b> Due to (or as a consequence of):  <b>oo.</b> Due to (or as a consequence of):  <b>pp.</b> Due to (or as a consequence of):  <b>qq.</b> Due to (or as a consequence of):  <b>rr.</b> Due to (or as a consequence of):  <b>ss.</b> Due to (or as a consequence of):  <b>tt.</b> Due to (or as a consequence of):  <b>uu.</b> Due to (or as a consequence of):  <b>vv.</b> Due to (or as a consequence of):  <b>ww.</b> Due to (or as a consequence of):  <b>xx.</b> Due to (or as a consequence of):  <b>yy.</b> Due to (or as a consequence of):  <b>zz.</b> Due to (or as a consequence of):  <b>aa.</b> Due to (or as a consequence of):  <b>bb.</b> Due to (or as a consequence of):  <b>cc.</b> Due to (or as a consequence of):  <b>dd.</b> Due to (or as a consequence of):  <b>ee.</b> Due to (or as a consequence of):  <b>ff.</b> Due to (or as a consequence of):  <b>gg.</b> Due to (or as a consequence of):  <b>hh.</b> Due to (or as a consequence of):  <b>ii.</b> Due to (or as a consequence of):  <b>jj.</b> Due to (or as a consequence of):  <b>kk.</b> Due to (or as a consequence of):  <b>ll.</b> Due to (or as a consequence of):  <b>mm.</b> Due to (or as a consequence of):  <b>nn.</b> Due to (or as a consequence of):  <b>oo.</b> Due to (or as a consequence of):  <b>pp.</b> Due to (or as a consequence of):  <b>qq.</b> Due to (or as a consequence of):  <b>rr.</b> Due to (or as a consequence of):  <b>ss.</b> Due to (or as a consequence of):  <b>tt.</b> Due to (or as a consequence of):  <b>uu.</b> Due to (or as a consequence of):  <b>vv.</b> Due to (or as a consequence of):  <b>ww.</b> Due to (or as a consequence of):  <b>xx.</b> Due to (or as a consequence of):  <b>yy.</b> Due to (or as a consequence of):  <b>zz.</b> Due to (or as a consequence of):  <b>aa.</b> Due to (or as a consequence of):  <b>bb.</b> Due to (or as a consequence of):  <b>cc.</b> Due to (or as a consequence of):  <b>dd.</b> Due to (or as a consequence of):  <b>ee.</b> Due to (or as a consequence of):  <b>ff.</b> Due to (or as a consequence of):  <b>gg.</b> Due to (or as a consequence of):  <b>hh.</b> Due to (or as a consequence of):  <b>ii.</b> Due to (or as a consequence of):  <b>jj.</b> Due to (or as a consequence of):  <b>kk.</b> Due to (or as a consequence of):  <b>ll.</b> 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Please Type or Print in Black Indelible Ink. ~~Amend Item 20 per Med Cert 6/19/97~~ All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28392

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John P. Clements</i>							2. Date of Death Month Aug Day 5 Year 2011	3. Time of Death 5:59 P.M.	
	4a. Facility Name (If not institution, give street and number) 4696 DULEY DRIVE			4b. City, Town, or Location of Death WHITE PLAINS			4c. County of Death CHARLES			
Funeral Director	5. Social Security Number 579-42-2133	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 8-27-1932	9. Birthplace (State or Foreign Country) MD.			
To Be Completed by Funeral Director	10a. State MD.			10b. County CHARLES			10c. City, Town or Location WALDORF			
	10e. Street and Number 6224 WOLVERINE PLACE			10f. Zip Code 20603			10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. NAVY KOREA		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 11th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business Industry P.G.C.O. DEPT. OF PUBLIC WORKS RET. SUPERVISOR			
	17. Father's Name (First, Middle, Last) JOHN MALCOMB CLEMENTS				18. Mother's Name (First, Middle, Maiden Surname) LILLIE CURTIN					
	19a. Informant's Name/Relationship (Type, Print) MELISSA B. CLEMENTS-DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6224 WOLVERINE PL. WALDORF. MD. 20603						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY			Date 8-8-11	20c. Location - City or Town, State ALEX., VA.		
	21. Signature of Funeral Service Licensee <i>Melissa O. S.</i>			22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Pancreatic Cancer</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 years	
	b. <i>[Blank]</i> Due to (or as a consequence of):									
	c. <i>[Blank]</i> Due to (or as a consequence of):									
	d. <i>[Blank]</i> Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>daughter residence</i>							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>Ashley L.</i>		29c. License number D 46246			29d. Date signed (Month, Day, Year) August 8, 2011				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>M. A. McElin MD</i>		31. Date filed (Month, Day, Year) SEP 07 2011							
			32. Registrar's Signature <i>Deanna J. Farrel</i>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N 2011 28393

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>Frank Anthony Cirillo</b>				2. Date of Death Month <b>August</b> Day <b>17</b> , Year <b>2011</b>	3. Time of Death 10:45 am
4a. Facility Name (if not institution, give street and number) <b>Montgomery Hospice-Casey House</b>				4b. City, Town, or Location of Death <b>Rockville</b>	
5. Social Security Number <b>114-12-9520</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours
				Min.	8. Date of Birth (Month, Day, Year) <b>March 11, 1917</b>
				9. Birthplace (State or Foreign Country) <b>NY</b>	
Usual Residence of Decedent 10a. State <b>MD</b>				10b. County <b>Montgomery</b>	
10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>728 Springloch Road</b>				10f. Zip Code <b>20904</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <b>1942-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Co-Director of Public Works, EDA</b>		16b. Kind of Business Industry <b>U.S. Dept. of Commerce</b>	
17. Father's Name (First, Middle, Last) <b>Raffaele Cirillo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florenza Casazza</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Eileen M. Coyne/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>728 Springloch Road, Silver Spring, MD 20904</b>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>	Date <b>Aug. 22, 2011</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): <b>Pneumonia</b></p> <p>b. Due to (or as a consequence of): <b>Dementia</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Thrombocytopenia, Hypertension, Dysphagia</b>					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospice</b>			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
					28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>R143201</b>		29d. Date signed (Month, Day, Year) <b>8/17/11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Debrah Miller, CRNP 1355 Piccard Drive, Rockville, MD 20850</b>					
31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature 			

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28394

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

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**Important:** If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death		
Arthur Conway	Month	Day	Year
4a. Facility Name (if not institution, give street and number)	3. Time of Death		
Anne Arundel Medical Center	08 18 2011 0505 AM		
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth
577-30-5390	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	85 Yrs.	Month Day Year May 19, 1926
9. Birthplace (State or Foreign Country) Maryland			
10. Usual Residence of Decedent			
10a. State	10b. County	10c. City, Town or Location	
Maryland	Prince George's	Bowie	
10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?
13101 Chestnut Drive		20715-0185	USA
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1946-47	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry
Elementary/Secondary (0-12) 8	College (1-4 or 5+)	Restaurateur	Business Owner
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
George Conway		Margaret Donnelly	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Michael H. Conway/ Son		206 N. 2nd Street Independence, KS 67301	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Fort Lincoln Cemetery	8/22/2011
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	
		Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715	

Division of Vital Records, P.O. Box 68760

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Immediate Cause (Final disease or condition resulting in death)			
23b. Part II. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			
23c. If yes, outcome of pregnancy			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
23d. Date of delivery			
Month Day Year			
23e. Did tobacco use contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23f. Did alcohol contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23g. Did illegal drugs contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23h. Did prescription drugs contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23i. Did medical error contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23j. Did patient self-harm contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23k. Did environmental factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23l. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23m. Did other factors contribute to the cause of death?			
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23n. Did other factors contribute to the cause of death?			
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23o. Did other factors contribute to the cause of death?			
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23p. Did other factors contribute to the cause of death?			
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23q. Did other factors contribute to the cause of death?			
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23r. Did other factors contribute to the cause of death?			
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23u. Did other factors contribute to the cause of death?			
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23v. Did other factors contribute to the cause of death?			
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23w. Did other factors contribute to the cause of death?			
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23x. Did other factors contribute to the cause of death?			
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23y. Did other factors contribute to the cause of death?			
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23aa. Did other factors contribute to the cause of death?			
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23bb. Did other factors contribute to the cause of death?			
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23cc. Did other factors contribute to the cause of death?			
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23dd. Did other factors contribute to the cause of death?			
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23ff. Did other factors contribute to the cause of death?			
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23gg. Did other factors contribute to the cause of death?			
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23hh. Did other factors contribute to the cause of death?			
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23ii. Did other factors contribute to the cause of death?			
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23jj. Did other factors contribute to the cause of death?			
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23kk. Did other factors contribute to the cause of death?			
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23ll. Did other factors contribute to the cause of death?			
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23mm. Did other factors contribute to the cause of death?			
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23nn. Did other factors contribute to the cause of death?			
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23oo. Did other factors contribute to the cause of death?			
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23pp. Did other factors contribute to the cause of death?			
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23qq. Did other factors contribute to the cause of death?			
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23rr. Did other factors contribute to the cause of death?			
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23tt. Did other factors contribute to the cause of death?			
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23uu. Did other factors contribute to the cause of death?			
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23vv. Did other factors contribute to the cause of death?			
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23ww. Did other factors contribute to the cause of death?			
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23yy. Did other factors contribute to the cause of death?			
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23aa. Did other factors contribute to the cause of death?			
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23bb. Did other factors contribute to the cause of death?			
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23kk. Did other factors contribute to the cause of death?			
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23ll. Did other factors contribute to the cause of death?			
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23mm. Did other factors contribute to the cause of death?			
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23nn. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23oo. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23pp. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23qq. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23rr. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23uu. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23vv. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ww. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23xx. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23yy. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23zz. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23aa. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23bb. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23cc. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23dd. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ee. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ff. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23gg. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23hh. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ii. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23jj. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23kk. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ll. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23mm. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23nn. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23oo. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23pp. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23qq. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23rr. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23uu. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23vv. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23ww. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23xx. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23yy. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23zz. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23aa. Did other factors contribute to the cause of death?			
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28395  
Reg. No.

**1-** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Elizabeth Gilliam Campbell</b>				2. Date of Death Month Day Year <b>August 19, 2011</b>	3. Time of Death <b>5:04 P M</b>
4a. Facility Name (if not institution, give street and number) <b>Bowie Health Care Center</b>		4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>228-12-9616</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>100 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>10/15/1910</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
Usual Residence of Decedent <b>Virginia</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>Virginia</b>	10b. County	10c. City, Town or Location <b>Lynchburg</b>			
10e. Street and Number <b>101 Briarwood Street</b>			10f. Zip Code <b>24503</b>		10g. Citizen of What Country? <b>U. S. A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Medical</b>	
17. Father's Name (First, Middle, Last) <b>Charles Bruce Gilliam</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Aleta Reynolds</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Jeanne Kline/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13203 Overbrook Lane, Bowie, Maryland 20715</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		Date <b>8/23/11</b>	20c. Location - City or Town, State <b>Lynchburg, Virginia</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715</b>			

**Physician/  
Medical  
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): <i>Cardiac Arrhythmia</i></p> <p>b. Due to (or as a consequence of): <i>Urinary Tract Infection</i></p> <p>c. Due to (or as a consequence of):  </p> <p>d. Due to (or as a consequence of):  </p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D-29097</b>		29d. Date signed (Month, Day, Year) <b>8/20/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3060 MITCHELLVILLE</b>		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>			
32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28396

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death					
MARY ELIZABETH CAREY		August 20, 2011				11:32 P M					
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
McCready Memorial Hospital			Crisfield			Somerset					
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 4, 1946	9. Birthplace (State or Foreign Country) Maryland				
Usual Residence of Decedent						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10a. State Maryland	10b. County Somerset	10c. City, Town or Location Crisfield				10g. Citizen of What Country? USA					
10e. Street and Number 4238 Strobel Lane			10f. Zip Code 21817			14. Race - American Indian, Black, White, etc. Specify: White					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16b. Kind of Business/Industry Disabled		16. Date							
17. Father's Name (First, Middle, Last) Alfred Turpin Dashiell				18. Mother's Name (First, Middle, Maiden Surname) Ruth Lurline Wilson							
19a. Informant's Name/Relationship (Type, Print) Robert Vance Carey (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 State Street - Crisfield, MD 21817								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Crematory of Delmarva		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva			20c. Location - City or Town, State Delmar, Delaware		Date 8/22/2011				
21. Signature of Funeral Service Licensee ► Mary Beth Bradshaw-Park		22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street-Crisfield, MD 21817									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lethal cardiac arrhythmia								Approximate Interval Between Onset and Death 10 days			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Congestive Heart Failure c. Ischemic cardiomyopathy d. Due to (or as a consequence of):								1 week 7 years			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) N/A			23d. Date of delivery Month Day Year N/A						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary Disease Tobacco Abuse								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number DOCS3262		29d. Date signed (Month, Day, Year) August 22, 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Whitaker, ms 305 10th Street, Suite 105 Second, ms 31857								31. Date filed (Month, Day, Year) AUG 23 2011			32. Registrar's Signature Kenna S. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28397

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH VIRGINIA CHERRIX</b>						2. Date of Death Month Day Year <b>August 20, 2011</b>	3. Time of Death <b>1:05 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Alice Byrd Tawes Nursing Home</b>			4b. City, Town, or Location of Death <b>Crisfield</b>			4c. County of Death <b>Somerset</b>	
Funeral Director	5. Social Security Number <b>213-22-8399</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>10/05/1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Somerset</b> 10c. City, Town or Location <b>Crisfield</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number <b>30 Anchor Drive</b>				10f. Zip Code <b>21817</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Cook</b>			16b. Kind of Business/Industry <b>Worcester County Jail</b>			
17. Father's Name (First, Middle, Last) <b>Levin Henry Kelly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Layfield</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patty M. Malin (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30 Anchor Drive - Crisfield, MD 21817</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Robert H. Bradshaw, Jr.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory of Delmarva</b>			Date <b>08/22/2010</b>	20c. Location - City or Town, State <b>Delmar, DE</b>		
21. Signature of Funeral Service Licensee <b>Bradshaw &amp; Sons Funeral Home</b> <b>306 W. Main St. - Crisfield, MD 21817</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>								
Approximate Interval Between Onset and Death								
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>D. Vijay Kaumbhakar</b>								
29c. License number <b>D 48098</b>								
29d. Date signed (Month, Day, Year) <b>8/20/2011</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Vijay Kaumbhakar 201 Hall Highway, Crisfield MD 21817</b>								
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature <b>Leanne A. Farrel</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28398

1- For State  
Registrar

Reg. No.

1. Decedent's Name (First, Middle, Last)  
**Eileen A. Curtis**2. Date of Death  
Month Day Year  
August 17, 20113. Time of Death  
1140 hrs**Physician/  
Medical Examiner**4a. Facility Name (if not institution, give street and number)  
**Shady Grove Adventist Hospital**4b. City, Town, or Location of Death  
**Rockville**4c. County of Death  
**Montgomery****Funeral  
Director**5. Social Security Number  
**028-26-2937** M F6. Sex  
**M**

7. Age (In yrs. last birthday)

**76**

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or  
Foreign Country)**MA**

Months

Days

Hours

Min.

**Dec. 4, 1934****To Be Completed by Funeral Director**10a. State  
**MD**10b. County  
**Montgomery**10c. City, Town or Location  
**Gaithersburg**10d. Inside City Limits  
**1  Yes 2  No**10e. Street and Number  
**8511 SNouffer School Rd., Apt. 1205**10f. Zip Code  
**20879**10g. Citizen of What Country?  
**USA**11. Marital Status  
**1  Never Married 2  Married**12. Was Decedent Ever in U.S. Armed Forces?  
**1  Yes 2  No**

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
or Dates:  
**1  Yes 2  No specify:**14. Race - American Indian, Black, White, etc.  
**Specify White**15. Decedent's Education (Specify only highest grade completed)  
**Elementary/Secondary (0-12) College (1-4 or 5+)**16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)  
**Teacher**16b. Kind of Business/Industry  
**Education**17. Father's Name (First, Middle, Last)  
**Michael Rourke**18. Mother's Name (First, Middle, Maiden Surname)  
**Nora Feeny**19a. Informant's Name/Relationship (Type, Print)  
**Patrick J. Curtis/Son**19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**15105 Watergate Road, Silver Spring, MD 20905**20a. Method of Disposition  
**1  Burial 2  Cremation 3  Removal from State**4  Donation 5  Other Specify  
**Metropolitan Crematory**20b. Place of Disposition (Name of cemetery,  
crematory or other place)  
**Metropolitan Crematory**Date  
**Aug. 20 2011**20c. Location - City or Town, State  
**Alexandria, VA**21. Signature of Funeral Service Licensee  
**Francis J. Collins Funeral Home Inc.**22. Name and Address of Facility  
**400 University Blvd. W., Silver Spring, MD 20901**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)  
**a. Hypertensive Atherosclerotic Cardiovascular Disease**Due to (or as a consequence of):  
**b. \_\_\_\_\_**Due to (or as a consequence of):  
**c. \_\_\_\_\_**Due to (or as a consequence of):  
**d. \_\_\_\_\_** **UNPENDED  AMENDED**IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
**1  Yes 2  No 9  Unknown**23c. If yes, outcome of pregnancy  
**1  Live birth 2  Fetal death 3  Ectopic pregnancy****4  Pregnant at time of death 5  Other (Specify)****9  Unknown**23d. Date of delivery  
**Month Day Year**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
**1  Yes 2  No 3  Probably 4  Unknown**24a. Was an autopsy performed?  
**1  Yes 2  No**24b. Were autopsy findings available prior to completion of cause of death?  
**1  Yes 2  No**25. Was case referred to medical examiner?  
**1  Yes 2  No**Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA 4  Nursing Home 5  Residence 6  Other:

26. Place of Death (Check only one)

27. Manner of Death  
**1  Natural 5  Pending Investigation****2  Accident 6  Could not be determined****3  Suicide 7  Homicide**28a. Date of Injury (Month, Day, Year)  
**28b. Time of Injury**28c. Injury at Work?  
**1  Yes 2  No**

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.  
(Specify)  
**28f. Location (Street and Number or Rural Route Number, City or Town, State)**29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
**2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.**29b. Signature and title of certifier  
**L. Ali, M.D.**29c. License number  
**O.C.M.E.**29d. Date signed (Month, Day, Year)  
**August 18, 2011**30. Name and address of person who completed cause of death (Item 23a)  
**Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223**31. Date filed (Month, Day, Year)  
**AUG 22 2011**32. Registrar's Signature  
**S. A. Curtis**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28399

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Deepali Chakrabarti</b>					2. Date of Death Month Day Year <b>August 20, 2011</b>	3. Time of Death 6:20 A M	
	4a. Facility Name (if not institution, give street and number) <b>7814 Maryknoll Avenue</b>					4b. City, Town, or Location of Death <b>Bethesda</b>	4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>030-52-8216</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 30, 1941</b>	9. Birthplace (State or Foreign Country) <b>India</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Bethesda</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>7814 Maryknoll Avenue</b>			10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian Indian</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher/Librarian</b>			16b. Kind of Business Industry <b>High School</b>		
	17. Father's Name (First, Middle, Last) <b>Sureswar Chatterjee</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rai Kishori Chatterjee</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Sujata Chakrabarti Pasic, daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7814 Maryknoll Avenue, Bethesda, Maryland 20817</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Ann Rave</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		Date <b>8/22/2011</b>	20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>M01102</b>		22. Name and Address of Facility <b>Simple Tribute</b> <b>1040 Rockville Pike, Rockville, Maryland 20852</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Renal Disease</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>6 mos.</b>		
	b. <b>Diabetes Mellitus Type II</b> Due to (or as a consequence of):					10 years		
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier <b>David Hirshfield MD</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Hirshfield, 10215 Fernwood Road Suite 100, Bethesda, Maryland 20817</b>					29c. License number <b>D0057896</b>		
	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>					29d. Date signed (Month, Day, Year) <b>August 20, 2011</b>		

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N.

2011 28400

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
<i>Shirley Collins</i>				<i>August 10, 2011</i>	<i>7:55 PM</i>
4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death	
<i>Northwest Hospital</i>				<i>Randallstown</i>	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct 17, 1935</i>
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Owings Mills</b>	
10e. Street and Number <b>10134 Shipes Lane</b>				10f. Zip Code <b>21117</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status  1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.  <i>11</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  <i>white</i>	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) <i>11</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <i>Manager</i>		16b. Kind of Business Industry  <i>Restaurant</i>	
17. Father's Name (First, Middle, Last)  <i>Clarence Feuchtenberger</i>				18. Mother's Name (First, Middle, Maiden Surname)  <i>Annie Dahlweiner</i>	
19a. Informant's Name/Relationship (Type, Print)  <i>Angela D. Louey, daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  <i>1401 Harney Road, Littlestown, PA 17340</i>	
20a. Method of Disposition  1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of  <i>Seven Carroll Crematory</i> )		Date  <i>8/15/2011</i>	20c. Location - City or Town, State  <i>Winfield, MD</i>
21. Signature of Funeral Service Licensee  <i>Justin R. Durboraw</i>		22. Name and Address of Facility  <i>Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157</i>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <i>Cryptic shock</i>					
Approximate Interval Between Onset and Death					
b. <i>Asthma</i> Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____ Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>End stage renal disease</i>					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  <i>Alice Hirsh</i>		29c. License number  <i>H43974</i>		29d. Date signed (Month, Day, Year)  <i>August 10, 2011</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <i>Alice Hirsh Northwest Hospital Randallstown, Maryland</i>					
31. Date filed (Month, Day, Year)  <i>AUG 15 2011</i>		32. Registrar's Signature  <i>Debbie A. Jones</i>			

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28401

Reg. No.

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1504 hrs
<b>Charles Daniel Collison</b>	August 14, 2011	

4a. Facility Name (if not institution, give street and number) <b>Frederick Memorial Hospital</b>	4b. City, Town, or Location of Death <b>Frederick</b>	4c. County of Death <b>Frederick</b>				
5. Social Security Number <b>204-32-8169</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>68 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>April 5, 1943</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>

**Funeral  
Director**

10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Jefferson</b>	10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
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10e. Street and Number <b>4306 Horine Court</b>	10f. Zip Code <b>21755</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White</b>	14. Race - American Indian, Black, White, etc.
--	---	--	--

15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Supervisor</b>	16b. Kind of Business/Industry <b>Government Printing Office</b>
--	--	---

17. Father's Name (First, Middle, Last) <b>Charles D. Collison</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Winifred McGarry</b>
19a. Informant's Name/Relationship (Type, Print) <b>Mary Charlene Collison - wife</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4306 Horine Court, Jefferson, Maryland 21755</b>

20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Stauffer Crematory</b>	Date <b>8-22-2011</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>
--	---	--------------------------	---

21. Signature of Funeral Service Licensee <b>Sharon Charlene Collison</b>	22. Name and Address of Facility <b>Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702</b>
--	---

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease</b>	Approximate Interval Between Onset and Death
--	--

Due to (or as a consequence of): <b>b.</b>	
---	--

Due to (or as a consequence of): <b>c.</b>	
---	--

Due to (or as a consequence of): <b>d.</b>	
---	--

<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>	23d. Date of delivery Month Day Year
--	---	--	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>
--	---

<b>24a. Was an autopsy performed?</b> <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	<b>24b. Were autopsy findings available prior to completion of cause of death?</b> <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
---	--

25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>	26. Place of Death (Check only one) Other <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:</b>
--	--	--

27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred
--	--	---------------------	---	-----------------------------------

5 <input type="checkbox"/> Pending Investigation	6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--	--	--

29a. Certifier <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 15, 2011</b>
---	--	---

30. Name and address of person who completed cause of death (Item 23a) <b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>	32. Registrar's Signature <b>[Signature]</b>
--	---

31. Date filed (Month, Day, Year) <b>August 16, 2011</b>	33. Date signed (Month, Day, Year) <b>August 15, 2011</b>
---	--

**Baltimore, MD 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician/  
Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Within 24 hours after death.

In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28402

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

patient karen davis  
permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial record.

20+

1. Decedent's Name (First, Middle, Last)

David Lee Davis

2. Date of Death

Month August

Day 17

Year 2011

3. Time of Death  
1019 PM

4a. Facility Name (if not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death  
Baltimore city

4c. County of Death

5. Social Security Number

214-36-3221

6. Sex

M

F

7. Age (In yrs. last birthday)  
70 Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 27, 1940

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

Yes  No

10e. Street and Number

1455 Old Annapolis Road

10f. Zip Code

21797

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates  
Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Firefighter

16b. Kind of Business Industry

Public Service

17. Father's Name (First, Middle, Last)

Bernard Davis

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Greene

19a. Informant's Name/Relationship (Type, Print)

Donna Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 Carroll Avenue, Mt. Airy, MD 21771

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

Aug. 24

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home Inc

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

1 day

sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

esophageal cancer

6 months

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

hypertension

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

24a. Was an autopsy performed?

Yes  No

24b. Were autopsy findings available prior to completion of cause of death?

Yes  No

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient  ER/Outpatient  DOA

Other:

Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  Homicide

28a. Date of injury

(Month, Day, Year)

M

28b. Time of injury

M

1  Yes  No

28c. Injury at work?

1  Yes  No

28d. Describe how injury occurred

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 17. 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunhee Park MD sinai hospital of Baltimore

31. Date filed (Month, Day, Year)

AUG 19 2011

2. Registrar's Signature



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28403

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Terry Lee Duckworth</b>							2. Date of Death Month <b>08</b> Day <b>23</b> Year <b>2011</b>	3. Time of Death <b>1630 M</b>		
	4a. Facility Name (If not institution, give street and number) <b>WMHS-Regional Medical Center</b>			4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>				
<b>Funeral Director</b>	5. Social Security Number <b>216-72-7141</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 21 1957</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>				
Usual Residence of Decedent 10a. State <b>WV</b> 10b. County <b>Mineral</b> 10c. City, Town or Location <b>Keyser</b> 10d. Inside City Limits <b>XXX Yes 2 <input type="checkbox"/> No</b>											
10e. Street and Number <b>12 North Main St., Apt. 406</b>				10f. Zip Code <b>26726</b>			10g. Citizen of What Country? <b>United States</b>				
<b>To Be Completed by Funeral Director</b>	11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Handyman</b>		16b. Kind of Business Industry <b>Construction</b>					
17. Father's Name (First, Middle, Last) <b>Robert Arthur Duckworth</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Clark</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Sarah Mason/ sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14902 Railroad St, Midland, Maryland 21532</b>							
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>			Date <b>09/25/2011</b>	20c. Location - City or Town, State <b>Cumberland Maryland</b>			
21. Signature of Funeral Service Licensee <b>F Wayne Bal</b>				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St, Westernport, Maryland 21562</b>							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CEREBROVASCULAR ACCIDENT</b>										Approximate Interval Between Onset and Death	
{ b. Due to (or as a consequence of): <b>RESPIRATORY FAILURE</b> c. Due to (or as a consequence of): d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>				23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>	
										24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>							
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>				28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <b>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> <b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. Signature and title of certifier <b>N. Qaisrani</b>				29c. License number <b>DO064167</b>						29d. Date signed (Month, Day, Year) <b>8/24/11</b>	
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. N. Qaisrani, 12501 Willowbrook Road, Cumberland, MD 21502</b>											
31. Date filed (Month, Day, Year) <b>AUG 25 2011</b>				32. Registrar's Signature <b>Sandra S. Parker</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.** 2011 28404

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

## 1- For State Registrar

**Physician/****Medical Examiner****Funeral Director****To Be Completed by Funeral Director**

**Baltimore, MD 21215-0036**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death 0622 hrs		
Dean Reginald Dixon		August 17, 2011					
4a. Facility Name (if not institution, give street and number) Woodfield Road in Cox Creek		4b. City, Town, or Location of Death Galesville			4c. County of Death Anne Arundel		
5. Social Security Number 214-72-0647		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9/10/1959		
10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Churchton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 5515 Baskin St.			10f. Zip Code 20733		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White	
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		If Yes, Give Year 77-81		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Mechanic Boat yard			
17. Father's Name (First, Middle, Last) Robert R. Dixon			18. Mother's Name (First, Middle, Maiden Surname) Delores Wilson				
19a. Informant's Name/Relationship (Type, Print) Mary K. Dixon Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Baskin St. Churchton, MD 20733					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		Date 8/18/2011	20c. Location - City or Town, State Glen Burnie, MD		
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  <i>J. J. O.</i>		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown _____	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury Month Day Year FOUND: Aug 17, 2011		28b. Time of Injury FOUND: 0622 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Creek				28d. Describe how injury occurred Subject recovered from water	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) August 18, 2011	
29b. Signature and title of certifier <i>Ana Rubio</i>		29c. License number O.C.M.E.					
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
31. Date filed (Month, Day, Year) AUG 19 2011		32. Registrar's Signature <i>Dean R. Dixon</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28405

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Dolores B. DeJan

2. Date of Death

Month

Day

Year

AUGUST 15 2011

6:45PM

3. Time of Death

4a. Facility Name (if not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

039-09-1173

6. Sex

M  F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

05/04/1920

9. Birthplace (State or Foreign Country)

Rhode Island

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

Yes  No

10e. Street and Number

904 Lake Front Drive

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Auditor

16b. Kind of Business Industry

Banking

17. Father's Name (First, Middle, Last)

George Barclay

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Forester

19a. Informant's Name/Relationship (Type, Print)

Marisa C. DeJan-Lenoir/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

904 Lake Front Drive, Mitchellville, MD 20721

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

8/22/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Hwy., Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Cerebrovascular Accident

a. Due to (or as a consequence of):

Atrial fibrillation

b. Due to (or as a consequence of):

Respiratory failure

c. Due to (or as a consequence of):

Sepsis

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify) \_\_\_\_\_  
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient

ER/Outpatient

DOA

Other:

Nursing Home

Residence

Other (Specify)

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  
 Homicide

28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 60925

29d. Date signed (Month, Day, Year)

8/17/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH FASICA A.D. 8118 GOOD LUCK ROAD LANHAM, MD 20706

31. Date filed (Month, Day, Year)

AUG 19 2011

32. Registrar's Signature

DeJan, Dolores

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28406

**1. For State Registrar**

<b>Physician/Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Lan Mu Do</b>	2. Date of Death Month Day Year <b>August 17, 2011</b>	3. Time of Death <b>0421 hrs</b>
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<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>3518 Cherryvale Drive</b>	4b. City, Town, or Location of Death <b>Beltsville</b>	4c. County of Death <b>Prince George's</b>
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<b>Funeral Director</b>	5. Social Security Number <b>212-96-2166</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>50</b>	If Under 1 Year Months <b>Yrs.</b>	If Under 24 Hrs. Hours <b>Min.</b>	8. Date of Birth (MM/DD/YYYY) <b>Sept. 29, 1960</b>	9. Birthplace (State or Foreign Country) <b>Vietnam</b>
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<b>Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>P.G.</b> 10c. City, Town or Location <b>Beltsville</b>						10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
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<b>Funeral Director</b>	10e. Street and Number <b>3518 Cherryvale Drive</b>	10f. Zip Code <b>20705</b>	10g. Citizen of What Country? <b>USA</b>
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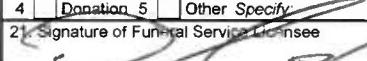
<b>Funeral Director</b>	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify: <b>Asian</b>	14. Race - American Indian, Black, White, etc. <b>Specify: Asian</b>
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<b>Funeral Director</b>	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Caregiver</b>	16b. Kind of Business/Industry <b>Eldercare</b>
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<b>Funeral Director</b>	17. Father's Name (First, Middle, Last) <b>Kien Loc Do</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Nu Ly</b>
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<b>Funeral Director</b>	19a. Informant's Name/Relationship (Type, Print) <b>Khan Thuy Do/Sister</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13809 Drake Drive, Rockville, MD 20853</b>
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<b>Funeral Director</b>	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Date of Heaven Cemetery</b>	Date <b>Aug. 25 2011</b>	20c. Location - City or Town, State <b>Silver Spring, MD</b>
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<b>Funeral Director</b>	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>
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<b>Physician/Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Sharp Force Injuries</b>	Approximate Interval Between Onset and Death
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<b>Physician/Medical Examiner</b>	Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>
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<b>Physician/Medical Examiner</b>	<b>UNPENDED</b> <input type="checkbox"/> <b>AMENDED</b> <input type="checkbox"/>
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<b>Physician/Medical Examiner</b>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown</b>	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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<b>Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
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<b>Physician/Medical Examiner</b>	24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
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<b>Physician/Medical Examiner</b>	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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<b>Physician/Medical Examiner</b>	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) <b>Aug 17, 2011</b>	28b. Time of Injury <b>0358 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Subject stabbed and cut
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<b>Physician/Medical Examiner</b>	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Single Family Home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3518 Cherryvale Drive, Beltsville, MD</b>
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<b>Physician/Medical Examiner</b>	29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician 2 <input checked="" type="checkbox"/> Medical Examiner</b>	29b. Signature and title of certifier 	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>August 17, 2011</b>
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<b>Physician/Medical Examiner</b>	30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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<b>Physician/Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>	32. Registrar's Signature 
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**Division of Vital Records, P.O. Box 68760,**  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

10

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

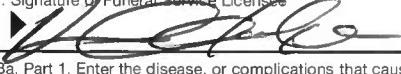
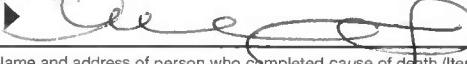
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28407

Reg. No.

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Esther Bader Diamond</b>				2. Date of Death Month Day Year <b>August 12, 2011</b>		3. Time of Death 6:45 AM					
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>					
Funeral Director		5. Social Security Number <b>107-22-0323</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months <b>11</b>	If Under 24 Hrs. Days <b>2</b>	Hours Min. <b>1929</b>	8. Date of Birth (Month, Day, Year) <b>11 / 2 / 1929</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			
To Be Completed by Funeral Director		10a. State <b>MD</b>				10b. County <b>Montgomery</b>				10c. City, Town or Location <b>Silver Spring</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number <b>3310 N. Leisure World Blvd.</b>				10f. Zip Code <b>20906</b>				10g. Citizen of What Country? <b>USA</b>			
Physician/ Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business Industry <b>Government</b>						
		17. Father's Name (First, Middle, Last) <b>Nathan Bader</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Baron</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Karen Harris / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Brookview Cr. Jamesburg, NJ 08831</b>							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Memorial Gardens</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		Date <b>08/14/2011</b>	20c. Location - City or Town, State <b>Olney, MD</b>				
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Edward Sage Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852</b>							
Medical Certificate: To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										Approximate Interval Between Onset and Death <b>2.5 Years</b>	
		<p>a. Due to (or as a consequence of): <b>Colon Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DS4378</b>				29d. Date signed (Month, Day, Year) <b>8-12-11</b>					
		29b. Signature and title of certifier 											
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cheryl Aylsworth M.D. 2730 University Blvd. W #400 Wheaton, MD 20902</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical  
Examiner**

1- For  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No.

2011 28408

**Funeral  
Director**

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Linda Deppe</i>				2. Date of Death Month 8 Day 21 Year 2011	3. Time of Death 12:44 PM
4a. Facility Name (if not institution, give street and number) <b>4007 BRIDGEPOINTE DRIVE</b>				4b. City, Town, or Location of Death <b>CHESTER</b>	
5. Social Security Number <b>219-40-1993</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) <b>MAY 14, 1944</b>
9. Birthplace (State or Foreign Country) <b>TENNESSEE</b>		10. Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>QUEEN ANNE'S</b> 10c. City, Town or Location <b>CHESTER</b>			
10e. Street and Number <b>4007 BRIDGEPOINTE DRIVE</b>				10f. Zip Code <b>21619</b>	10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>BOOKKEEPER</b>		16b. Kind of Business Industry <b>SOFTWARE</b>	
17. Father's Name (First, Middle, Last) <b>HOWARD DENTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>L. LORRAINE MOORE</b>	
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT E. DEPPE, SR./HUSBAND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4007 BRIDGEPOINTE DRIVE, CHESTER, MD 21619</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CENTER</b>		Date <b>08/23/2011</b>	20c. Location - City or Town, State <b>STEVENSVILLE, MD</b>
21. Signature of Funeral Service Licensee <i>Robert E. Deppe</i>		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>2 years</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. _____ Due to (or as a consequence of): <i>Lung cancer</i></p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Jay Rhee</i>			
		29c. License number <b>00064379</b>		29d. Date signed (Month, Day, Year) <b>8/22/11</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jay Rhee 2003 medical Parkway Suite 210 Annapolis MD 21401</i>					
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature <i>Leanne B. Space</i>			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28409

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show  
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 once.

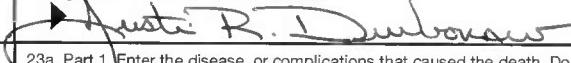
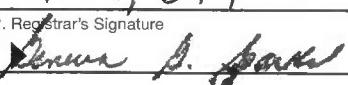
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filled in by the funeral director, page 2 should be detached (for use as the burial-transit  
 permit).

## Division of Vital Records, P.O. Box 68760

WJL  
2

## Medical Certificate: To Be Completed by Physician/Medical Examiner

## To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Raul Diaz</b>				2. Date of Death Month <b>August</b> Day <b>13</b> Year <b>2011</b>		3. Time of Death 3:00 a m	
4a. Facility Name (if not institution, give street and number) <b>Transitions Healthcare Center</b>				4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>095-24-7607</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Mar 13, 1920</b>	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>
Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Carroll</b>				10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>47 Carroll Street</b>				10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Puerto Rican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cab Driver</b>			16b. Kind of Business Industry <b>Transportation</b>	
17. Father's Name (First, Middle, Last) <b>Braulio Diaz Alago</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Juanita Diaz</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Myriam Diaz, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>47 Carroll Street, Westminster, MD 21157</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Los Jardin Cemetery</b>			Date <b>8/18/2011</b>	20c. Location - City or Town, State <b>Isabela, Puerto Rico</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): <b>DEMENTIA</b></p> <p>b. Due to (or as a consequence of): <b>DEPRESSION</b></p> <p>c. Due to (or as a consequence of): <b>C. A. D.</b></p> <p>d.</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D-0054218</b>				29d. Date signed (Month, Day, Year) <b>08-15-2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. Ramon B. Kanengs, 349 Malcolm Drive, Westminster, MD 21157</b>		32. Registrar's Signature 				31. Date filed (Month, Day, Year) <b>AUG 15 2011</b>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28410

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		Dorsey		2. Date of Death Month 8 Day 16 Year 11 15:15 M	3. Time of Death
Robert S					
4a. Facility Name (if not institution, give street and number)		Fort Washington		4c. County of Death Prince George	
Fort Washington					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 82	If Under 1 Year Months	If Under 24 Hrs. Hours
220-16-8769					Min.
Usual Residence of Decedent		10c. City, Town or Location Fort Washington		8. Date of Birth (Month, Day, Year) 8-13-29	
10a. State Maryland		10b. County Prince George		9. Birthplace (State or Foreign Country) Maryland	
10e. Street and Number 12015 Ft. Washington Rd		10f. Zip Code 20744		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1950 1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner		16b. Kind of Business Industry Dry Cleaning	
17. Father's Name (First, Middle, Last) Robert M. Dorsey		18. Mother's Name (First, Middle, Maiden Surname) Doris Frederick Dorsey			
19a. Informant's Name/Relationship (Type, Print) Constance D Thomas-Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12015 Fort Washington Rd, Ft. Washington, MD 20744			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet		Date 8-23-11	20c. Location - City or Town, State Washington DC
21. Signature of Funeral Service Licensee ► Theresa Neal		22. Name and Address of Facility Adams Funeral Home P, Agnew MD 20608			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Coronary artery disease		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Hypertension			
a. Due to (or as a consequence of): Coronary artery disease		Chronic kidney disease			
b. Due to (or as a consequence of): Hypertension		Chronic kidney disease			
c. Due to (or as a consequence of): Chronic kidney disease					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier ► Laxmi Berwa		29c. License number D-24535		29d. Date signed (Month, Day, Year) 08/17/11	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa 7700 Old Branch Ave. Suite C101 Clinton Md. 20735					
31. Date filed (Month, Day, Year) AUG 22 2011		32. Registrar's Signature Laxmi S. Berwa			

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 25 per med cert G919 9716/11 dk

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28411

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sara E. Detwiler

2. Date of Death

Month Day Year

3. Time of Death

5:25AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Manokin Manor

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

5. Social Security Number

219-36-6739

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

102

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

Month Day Year

Months Days Hours Min.

Dec. 10, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Westover

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

7278 Mennonite Church Road

10f. Zip Code

21871

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

David Kurtz

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Moseman

19a. Informant's Name/Relationship (Type, Print)

Mildred Good/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7187 Mennonite Church Road, Westover, MD 21871

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Grove Menn. Cem

Date

8/26/2011

20c. Location - City or Town, State

Westover, MD 21871

21. Signature of Funeral Service Licensee

Michael A Dean

22. Name and Address of Facility

Holloway Funeral Home, P.A.  
107 Vine St., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

DEMENTIA

Approximate Interval Between Onset and Death

5 years

Physician  
/Medical  
Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DR. U. NATESAN

29c. License number

2051359

29d. Date signed (Month, Day, Year)

August 22nd 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. U. NATESAN. 1415-S DIVISION ST, SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

AUG 23 2011

32. Registrar's Signature

SARAH B. SPARKS

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

#25 voice

8/22/2011

E.T. 2

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28412

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Wilbur S. Ervin, Jr.</i>		August 20 2011		1310 P M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>1009 Leslie Road</i>		<i>Havre de Grace</i>		<i>Harford</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>87</i>	8. Date of Birth (Month, Day, Year) <i>Feb. 06, 1924</i>
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) <i>Maryland</i>
Usual Residence of Decedent		10a. State <i>MD</i>		10b. County <i>Harford</i>
10c. City, Town or Location <i>Havre de Grace</i>		10f. Zip Code <i>21078</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>1009 Leslie Road</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Civil Service</i>		16b. Kind of Business/Industry <i>Meteorologist</i>
17. Father's Name (First, Middle, Last) <i>Wilbur S. Ervin, Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Laura Crawford</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Stefania Crum (Daughter)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>911 Valley Lane, Oreland, Pennsylvania 19075</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>R.A. Ferris &amp; Co, Inc.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Zelman Funeral Home, P.A.</i>	Date <i>08/23/2011</i>	20c. Location - City or Town, State <i>West Chester, PA</i>
21. Signature of Funeral Service Licensee <i>Yael C. Bellman</i>		22. Name and Address of Facility <i>123 S. Washington St., Havre de Grace, MD 21078</i>		
Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>Severe COPD</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <i>Severe COPD</i>		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's</i> <i>CAD</i> <i>DM</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>SHAHNAWAZ KHAN</i>		29c. License number <i>D0062190</i>		29d. Date signed (Month, Day, Year) <i>8/22/2011</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SHAHNAWAZ KHAN, 2533 AUGUSTINE HERMAN Hwy, SUITE A, CHESTER CITY, MD, 21915</i>				
31. Date filed (Month, Day, Year) <i>AUG 22 2011</i>		32. Registrar's Signature <i>Leanne S. Parker</i>		

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28413

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)  
**Suzanne Frances Finn**

2. Date of Death  
Month Day Year  
**August 18, 2011**

3. Time of Death  
**2:25 PM**

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)  
**Sacred Heart Home**

4b. City, Town, or Location of Death  
**Hyattsville**

4c. County of Death  
**Prince George's**

5. Social Security Number  
**579-24-5317**

6. Sex  
**M**

7. Age (In yrs. last birthday)  
**99**

Yrs.

If Under 1 Year  
Months Days Hours Min.

If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)  
**Nov. 2, 1911**

9. Birthplace (State or Foreign  
Country)  
**Washington, DC**

Usual Residence of Decedent  
10a. State  
**MD**

10b. County  
**Prince George's**

10c. City, Town or Location  
**Hyattsville**

10d. Inside City Limits  
**Yes**

10e. Street and Number  
**5805 Queens Chapel Road**

10f. Zip Code  
**20782**

10g. Citizen of What Country?  
**USA**

11. Marital Status  
1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.  
Specify:  
**White**

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) **8**

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)  
College (1-4 or 5+) **Keypunch Supervisor**

16b. Kind of Business Industry  
**Central Intelligence Agency**

17. Father's Name (First, Middle, Last)  
**Joseph Hurst**

18. Mother's Name (First, Middle, Maiden Surname)  
**Mary Estelle McNerney**

19a. Informant's Name/Relationship (Type, Print)  
**Linda Getgen / Granddaughter**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**9790 Penns Hill Road, La Plata, MD 20646**

20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
**Arlington National Cemetery**

Date  
**9/29/2011**

20c. Location - City or Town, State  
**Arlington, Virginia**

21. Signature of Funeral Service Licensee  


22. Name and Address of Facility  
**Gasch's Funeral Home, P.A. Hyattsville, MD 20781**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

**End Stage Dementia**

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate Interval Between Onset and Death

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify) \_\_\_\_\_  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

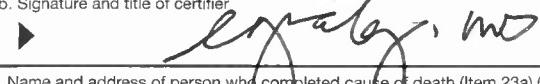
27. Manner of Death  
1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)  
28b. Time of injury  
M  
28c. Injury at work?  
1  Yes 2  No  
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  


29c. License number

D051122

29d. Date signed (Month, Day, Year)

August 19, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**Esmeraldo O. Juanitez, MD, 1160 Varnum Street, NE, #008, Washington, DC 20017**

31. Date filed (Month, Day, Year)  
**AUG 22 2011**

32. Registrar's Signature  


Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certificate To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State  
Registrar**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28414

**1- For State Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>John Farrington</b>							2. Date of Death Month Day Year August 20, 2011	3. Time of Death 2348 hrs	
	4a. Facility Name (if not institution, give street and number) <b>Fort Washington Hospital Center</b>							4b. City, Town, or Location of Death <b>Fort Washington</b>	4c. County of Death <b>Prince George's</b>	
<b>Funeral Director</b>	5. Social Security Number <b>246-66-6672</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>April 17, 1943</b>	9. Birthplace (State or Foreign Country) <b>NC</b>		
	10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Fort Washington</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>2117 Browns Lane</b>				10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Service Agent</b>		16b. Kind of Business/Industry <b>Private</b>				
17. Father's Name (First, Middle, Last) <b>John Thomas Farrington</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Hackney</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Arnetta M. Farrington/Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2117 Browns Lane, Fort Washington, MD 20744</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>Burial 10/10/85</b>					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Terrell's Creek Baptist Cemetery</b>		Date <b>8/27/2011</b>	20c. Location - City or Town, State <b>Chapel Hill, NC</b>		
21. Signature of Funeral Service Licensee <b>Victor Weeden MD JD</b>					22. Name and Address of Facility <b>Pope Funeral, Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20746</b>					
<b>Physician /Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Approximate Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death) <b>a. Cirrhosis of the Liver</b>										
Due to (or as a consequence of):										
b. Chronic Alcohol Use										
Due to (or as a consequence of):										
c.										
D. Due to (or as a consequence of):										
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a-b, pt. II, 27, per me, g919 9-9-11 sm								
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) <b>9 <input type="checkbox"/> Unknown</b>						23d. Date of delivery Month Day Year		
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Diabetes</b>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred		
						1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		28e. Place of Injury - At home, farm, street, factory, office building, etc.						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <b>Victor Weeden MD JD</b>		29c. License number <b>O.C.M.E.</b>						29d. Date signed (Month, Day, Year) <b>August 21, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>										
31. Date filed (Month, Day, Year) <b>AUG 29 2011</b>				32. Registrar's Signature <b>James J. Parker</b>						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28415

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1  Yes 2  No  
g  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown24a. Was an autopsy performed?  
1  Yes 2  No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1  Yes 2  No25. Was case referred to medical  
examiner?  
1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending  
2  Accident Investigation  
3  Suicide 6  Could not be  
determined  
4  Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?  
M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
only one) 3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Manohar K. Chenchugalla, MD

29c. License number

D0067876

29d. Date signed (Month, Day, Year)

8/12/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manohar K. Chenchugalla, M.D. - 12501 Willowbrook Road, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

AUG 16 2011

32. Registrar's Signature

Leanne J. Parker

ORIGINAL

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28416

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

dru 10

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<b>CLARENCE R. FENSTERMACHER</b>		08 12 2011		0200 M
4a. Facility Name (if not institution, give street and number) <b>6917 Halleck Street</b>		4b. City, Town, or Location of Death <b>District Heights</b>		4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>171-28-0742</b>		6. Sex <b>M</b>	7. Age (in yrs. last birthday) <b>76 Yrs.</b>	8. Date of Birth (Month, Day, Year) <b>08/22/1934</b>
9. Usual Residence of Decedent <b>MD</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>District Heights</b>	
10e. Street and Number <b>6917 Halleck Street</b>		10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>Never Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>Yes</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>No</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business Industry <b>Local 1590</b>
17. Father's Name (First, Middle, Last) <b>Ralph Fenstermacher</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Millie Rexrode</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Fenstermacher/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6917 Halleck Street, District Heights, MD 20747</b>		
20a. Method of Disposition <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>	Date <b>08/15/2011</b>	20c. Location - City or Town, State <b>Clinton, MD</b>
21. Signature of Funeral Service Licensee <b>Lisa M. Mounts</b>		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. <b>8200 Jennifer Lane, Owings, MD 20736</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<i>Dementia</i>		Approximate Interval Between Onset and Death <b>Year</b>
23b. If FEMALE: Was decedent pregnant in the past 12 months? <b>Yes</b>		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>Yes</b>
25. Was case referred to medical examiner? <b>Yes</b>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <b>Yes</b>
27. Manner of Death <b>Natural</b> <b>Accident</b> <b>Suicide</b> <b>Homicide</b>		28a. Date of injury (Month, Day, Year) <b>August 15 2011</b>	28b. Time of injury <b>M</b>	28c. Injury at work? <b>Yes</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>	28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>Michael J. LaPenta</b>		29c. License number <b>021438</b>		29d. Date signed (Month, Day, Year) <b>August 15 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. LAPENTA MD 445 Defense Hwy, Annapolis MD 21401</b>				
31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature <b>Anna S. Patel</b>		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28417

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

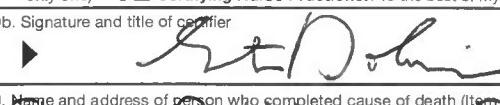
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Margaret Ann Feather</b>			2. Date of Death Month <b>August</b> Day <b>12</b> , Year <b>2011</b>	3. Time of Death 3:30 P.M.
4a. Facility Name (if not institution, give street and number) <b>Wilson Health Care Center</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>	
5. Social Security Number <b>186-26-4701</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth Month <b>Dec.</b> Day <b>6</b> , Year <b>1930</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Gaithersburg</b>		
10e. Street and Number <b>201 Russell Avenue</b>			10f. Zip Code <b>20877</b>	10g. Citizen of What Country? <b>United States</b>
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b> Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business Industry <b>Education</b>
17. Father's Name (First, Middle, Last) <b>Howard</b> <b>Feather</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret</b> <b>Shaub</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Linda Thompson/Power of Attorney</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5811 Lone Oak Drive, Bethesda, MD 20814</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, other place) <b>Geo. Wash. University Medical Center</b>	Date <b>Aug. 12 2011</b>	20c. Location - City or Town, State <b>Washington, D.C.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Columbia Mortuary Services, P.A.</b> <b>9013 Annapolis Road, Lanham, MD 20724</b>		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>dementia</b>		•Approximate Interval Between Onset and Death <b>yo20</b>			
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Was decedent pregnant In the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>0.20A8</b>			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>August 12 2011</b>			
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) <b>Steven Dolinsky</b> <b>911 Russell Ave. Gaithersburg MD</b>		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>			
32. Registrar's Signature 					

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

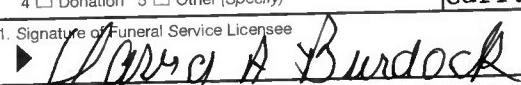
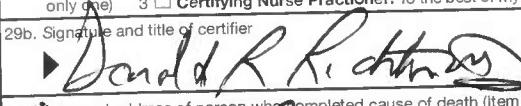
**Certificate of Death**

Reg. No.

2011 28418

**1 - For State Registrar**

**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)		2. Date of Death				
Frank Milton Fletcher Jr		Month	Day	Year	3. Time of Death	
		08	21	2011	6:14 a M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				
55 Tillson McGraw St		Deer Park				
4c. County of Death		4d. Birthplace (State or Foreign Country)				
Garrett		Washington, DC				
5. Social Security Number		6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	
577-40-6012		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	81 Yrs.	Months	Days Hours Min.	
10a. Usual Residence of Decedent		10c. City, Town or Location				
MD		Deer Park				
10e. Street and Number		10f. Zip Code				
55 Tillson McGraw St		21550				
10g. Citizen of What Country?						
		USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry
Elementary/Secondary (0-12) 9		truck driver				food
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)				
Frank M. Fletcher		Geneva M. Seiders				
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Carolyn B. Fletcher-wife		55 Tillson McGraw St, Deer Park, MD 21550				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Garr. Co. Mem. Gardens		8/26/2011	Oakland, MD	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility				
		David A. Burdock Funeral Home, PA				
		21 N 2nd St, Oakland, MD 21550				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)		<i>Non small cell carcinoma of lung</i>				Approximate Interval Between Onset and Death 3 months
23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy		23d. Date of delivery		
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?
						1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner?		26. Place of Death (Check only one)				
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				M	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
29a. Certifier (Check only one)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)		
		D 30035		08/23/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
Donald R. Richter MD 1027 MEMORIAL Drive OAKLAND MD 21550						
31. Date filed (Month, Day, Year)		32. Registrar's Signature				
AUG 23 2011						

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

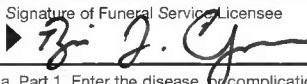
Certificate of Death

Reg. No.

2011 28419

For  
State  
Registrar

Physician/  
Medical  
Examiner

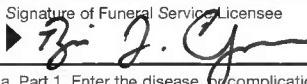
1. Decedent's Name (First, Middle, Last) <b>Louise E. Fosler</b>		2. Date of Death Month Day Year <b>August 19, 2011</b>		3. Time of Death 2:35 AM
4a. Facility Name (if not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>438-46-8911</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth Month Day Year <b>01/15/1935</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crownsville</b>
10e. Street and Number <b>555 Palisades Blvd.</b>		10f. Zip Code <b>21032</b>		10g. Citizen of What Country? <b>' USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>1</b>		16b. Kind of Business Industry <b>Loan Officer</b>
17. Father's Name (First, Middle, Last) <b>Carl H. Allen</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lily Coy Hart</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Donald M. Fosler (spouse)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>555 Palisades Blvd. Crownsville, MD 21032</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>		Date <b>8/20/2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home P.A.</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>ADVANCED BREAST CANCER</b>		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. Describe how injury occurred		
29b. Signature and title of certifier 		29c. License number <b>00064852</b>		29d. Date signed (Month, Day, Year) <b>08/19/2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raven J. Gare MD</b>		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		
		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>Louise E. Fosler</b>		2. Date of Death Month Day Year <b>August 19, 2011</b>		3. Time of Death 2:35 AM
4a. Facility Name (if not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>438-46-8911</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth Month Day Year <b>01/15/1935</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crownsville</b>
10e. Street and Number <b>555 Palisades Blvd.</b>		10f. Zip Code <b>21032</b>		10g. Citizen of What Country? <b>' USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>1</b>		16b. Kind of Business Industry <b>Loan Officer</b>
17. Father's Name (First, Middle, Last) <b>Carl H. Allen</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lily Coy Hart</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Donald M. Fosler (spouse)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>555 Palisades Blvd. Crownsville, MD 21032</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Atlantic Crematory</b>		Date <b>8/20/2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home P.A.</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>ADVANCED BREAST CANCER</b>		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. Describe how injury occurred		
29b. Signature and title of certifier 		29c. License number <b>00064852</b>		29d. Date signed (Month, Day, Year) <b>08/19/2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raven J. Gare MD</b>		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		
		32. Registrar's Signature 		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #23a&b Perphy G919 9/08/2011 Jh

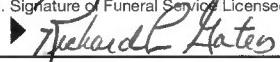
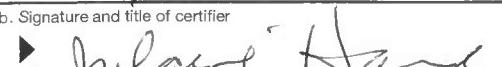
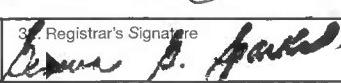
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28420  
Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Mary Martha Fluhr		August 17, 2011		10:50 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Renaissance Gardens at Riderwood Village		Silver Spring		P.G.
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 23, 1938
154-28-9321				g. Birthplace (State or Foreign Country) NJ
Usual Residence of Decedent		10a. State MD 10b. County PG 10c. City, Town or Location Silver Spring		
		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3160 Gracefield Road, Apt. 3308		10f. Zip Code 20904		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business Industry Education
College (1-4 or 5+) 5+				
17. Father's Name (First, Middle, Last) Stanley Edward Franey		18. Mother's Name (First, Middle, Maiden Surname) Ruth C. Bywater		
19a. Informant's Name/Relationship (Type, Print) Edward M. Fluhr/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Cody Drive, Silver Spring, MD 20902		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date Aug. 18 2011	20c. Location - City or Town, State Alexandria, VA
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>End Stage Dementia</b> <b>Parkinson Disease</b>		Approximate Interval Between Onset and Death <b>1 yr 8 yrs</b>
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of): <b>Parkinson's Disease</b>		<b>18 yrs</b>
23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		
23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):		
23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):		
23k. Due to (or as a consequence of):		23l. Due to (or as a consequence of):		
23m. Due to (or as a consequence of):		23n. Due to (or as a consequence of):		
23o. Due to (or as a consequence of):		23p. Due to (or as a consequence of):		
23q. Due to (or as a consequence of):		23r. Due to (or as a consequence of):		
23s. Due to (or as a consequence of):		23t. Due to (or as a consequence of):		
23u. Due to (or as a consequence of):		23v. Due to (or as a consequence of):		
23w. Due to (or as a consequence of):		23x. Due to (or as a consequence of):		
23y. Due to (or as a consequence of):		23z. Due to (or as a consequence of):		
24a. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
24e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24f. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Julaine Harding, CRNP		
		29c. License number R 112633	29d. Date signed (Month, Day, Year) 8/18/11	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julaine Harding, CRNP 3110 Gracefield Road, Silver Spring, MD 20904				
31. Date filed (Month, Day, Year) AUG 19 2011		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial form.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28421

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	Amelia A. Frank			2. Date of Death	Month Day Year		3. Time of Death	
Brooke Grove Rehabilitation and Nursing Center			Sandy Spring			August 20, 2011		2108 M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death			

Funeral  
Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
577-54-2881	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	102 Yrs.	Months	Days	Month Day Year	March 22, 1909	

Usual Residence of Decedent

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?
15311 Beaverbrook Court, #2H		20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1942-69	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	White Specify:

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry
Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Teacher Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John G. Abele	Mary Vogt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Isabella B. Donnelly/Executor	13407 Crispin Way, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	Assumption Cemetery	Aug. 25, 2011	Cortlandt Manor, NY

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. myocardial infarction Due to (or as a consequence of):	MINUTES
b. coronary artery disease Due to (or as a consequence of):	years
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - <i>chronic obstructive pulmonary disease</i>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number	29d. Date signed (Month, Day, Year)
--	---------------------	-------------------------------------

29b. Signature and title of certifier 	D42046	August 22, 2011
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Grace Brooke Huffman, M.D., 18100 Slade School Road Sandy Spring Maryland 20860

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 23 2011	

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760

9/1

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28422

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

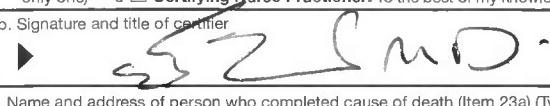
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached or use as the burial/transit

20

Physician/  
Medical  
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death		
<b>Kathleen Larcombe Freese</b>				<b>August 15, 2011</b>				<b>1830 M</b>		
4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
<b>Shady Grove Adventist Hospital</b>				<b>Rockville</b>				<b>Montgomery</b>		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>SEP 12, 1930</b>	9. Birthplace (State or Foreign Country) <b>DC</b>	
<b>219-64-4346</b>		<b>80</b>	<b>Yrs.</b>							
Usual Residence of Decedent				10c. City, Town or Location					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		<b>Gaithersburg</b>						
10e. Street and Number <b>419 Russell Avenue, #520</b>				10f. Zip Code <b>20877</b>				10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Recreation Director</b>			16b. Kind of Business Industry <b>County Government</b>				
17. Father's Name (First, Middle, Last) <b>John S. Larcombe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Olive Gallagher</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mary K. Foster / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2001 Indian Head Rd., Towson, MD 21204</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of Cemetery, crematory or other place) <b>Uniformed Services Univ. of the Health Sciences</b>				Date <b>AUG 18, 2011</b>	20c. Location - City or Town, State <b>Bethesda, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Tibadeau Mortuary Service. p.a.</b> <b>7 Park Avenue, Gaithersburg, MD 20877</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <b>Aspiration pneumonia</b>					Approximate Interval Between Onset and Death	
				23c. Due to (or as a consequence of): <b>restrictive lung disease</b>						
				23d. Due to (or as a consequence of): <b>left phrenic paralysis</b>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Morbid obesity</b> <b>Atrial Fibrillation</b> <b>Congestive Heart Failure</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number <b>62435</b>						29d. Date signed (Month, Day, Year) <b>August 16, 2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sayed El Sayyad MD</b>				31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>					32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28423

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Bethy J. Ford  
Baltimore, Maryland 21215-0036  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 08 Day 18 Year 2011		3. Time of Death 1:30 A M
BETTY JANE FORD				
4a. Facility Name (if not institution, give street and number) <b>Coastal Hospice At the Lake</b>		4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>
5. Social Security Number <b>213-42-2288</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) <b>Dec. 14, 1941</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>				
10a. State <b>MD</b>		10b. County <b>Worcester</b>	10c. City, Town or Location <b>Pocomoke City</b>	
10e. Street and Number <b>1505 Cedar Street</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business Industry <b>Domestic</b>	
17. Father's Name (First, Middle, Last) <b>Norris William Taylor, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Ellen Pruitt</b>		
19a. Informant's Name/Relationship (Type, Print) <b>William Clyde Ford/ Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1505 Cedar Street, Pocomoke City, MD 21851</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>	Date <b>8/23/2011</b>	20c. Location - City or Town, State <b>Salisbury, MD</b>
21. Signature of Funeral Service Licensee <b>Michael A Dean</b>		22. Name and Address of Facility <b>Holloway Funeral Home, P.A. 107 Vine St., Pocomoke City, MD 21851</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <b>MALIGNANT MELANOMA</b>				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>HOSPIC R</b>		
27. Manner of Death Natural Accident Pending Investigation Suicide Could not be determined Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0058410</b>		
29b. Signature and title of certifier <b>J. WARDY</b>		29d. Date signed (Month, Day, Year) <b>8/18/2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Affiliam Wardy PO BOX 1733 STATION MD 21802</b>				
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature <b>Laura S. Parker</b>		

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28424

## 1- For State Registrar

Reg. No.

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1830 hrs
Dwight Gaiter	August 10, 2011	

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Cheverly	4c. County of Death Prince George's
Prince George's Hospital		

**Funeral Director**

5. Social Security Number 219-53-0793	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 26 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 09/03/1984	9. Birthplace (State or Foreign Country) DC
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10a. State MD	10b. County Prince George's	10c. City, Town or Location Capital Heights	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 4325 Will Street	10f. Zip Code 20743	10g. Citizen of What Country? United States
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Cook	16b. Kind of Business/Industry Private
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17. Father's Name (First, Middle, Last) Kenneth Session	18. Mother's Name (First, Middle, Maiden Surname) Dawn Gaiter
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19a. Informant's Name/Relationship (Type, Print) Dawn Wherry/Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4325 Will Street, Capital Heights, MD 20743
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Washington National	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 08/19/2011	20c. Location - City or Town, State Suitland, MD
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21. Signature of Funeral Service Licensee Keith A. Gaiter M01085	22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747
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**Baltimore, MD 21215-0036**

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Stab Wound to Right Lower Extremity	
Due to (or as a consequence of):	

**Physician /Medical Examiner**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Aug 9, 2011	28b. Time of Injury FOUND: 0020 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject was assaulted
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ground	28f. Location (Street and Number or Rural Route Number, City or Town, State) 400 Block of 56th St. NE, Washington, DC,
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier Pamela E. Southall, MD Assistant Medical Examiner	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 11, 2011
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30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) AUG 22 2011	32. Registrar's Signature Lorraine A. Gaiter
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**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

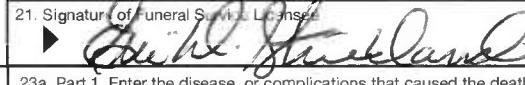
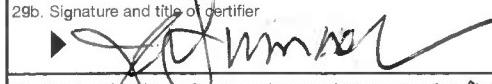
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28425

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTHEW AJANI GRANT</b>						2. Date of Death Month Day Year <b>August 15, 2011</b>	3. Time of Death 4:00 A M			
	4a. Facility Name (if not institution, give street and number) <b>Southern Maryland Hospital</b>			4b. City, Town, or Location of Death <b>Clinton</b>			4c. County of Death <b>Prince Georges</b>				
Funeral Director	5. Social Security Number <b>217-98-6655</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>29</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-24-82</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Fort Washington</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>6702 Border Place</b>			10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Janitor</b>			16b. Kind of Business Industry <b>Goodwill Industries</b>				
	17. Father's Name (First, Middle, Last) <b>Michael Grant</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sherrill Jones</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Michael Grant / Father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6702 Border Place, Fort Washington, MD 20744</b>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>			Date <b>08-17-2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748</b>								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>pneumonia</b>								Approximate Interval Between Onset and Death <b>1 day</b>		
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>sepsis</b>										
	c. Due to (or as a consequence of) <b>respiratory failure</b>										
	d. Due to (or as a consequence of) <b>renal failure</b>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumothorax, hyperkalemia</b>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 		29c. License number <b>D25753</b>			29d. Date signed (Month, Day, Year) <b>08-16-2011</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7503 Surratts Road, Clinton, MD 20735</b>										
	31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

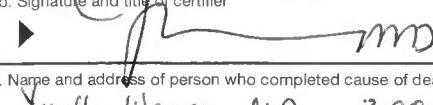
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28426

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Verna J. Guercio</b>					2. Date of Death Month Day Year <b>August 18, 2011</b>	3. Time of Death 6:00P M	
	4a. Facility Name (if not institution, give street and number) <b>Buckingham's Choice</b>			4b. City, Town, or Location of Death <b>Adamstown</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>212-01-7416</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug 1, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Frederick</b>			10c. City, Town or Location <b>Adamstown</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>3200 Baker Circle</b>			10f. Zip Code <b>21710</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>1</b> Homemaker		16b. Kind of Business Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Henry Douglas Scriba</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Beatrice Dove</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Stephen Guercio/son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11695 Binary Court Monrovia, Maryland 21770</b>		Date <b>8/22/2011</b>	20c. Location - City or Town, State <b>Marriottsville, MD</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043</b>					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CVA</b>							Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Medical Certificate: To Be Completed by Physician/Medical Examiner	a. Due to (or as a consequence of): <b>CVA</b>	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 	29c. License number <b>D0058726</b>			29d. Date signed (Month, Day, Year) <b>8-19-11</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yvette Warren MD 3000 D Ventrie Ct, Myersville MD 21773</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28427

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Margaret Gipe			2. Date of Death Month Day Year August 7, 2011			3. Time of Death 10:30 A M		
	4a. Facility Name (If not institution, give street and number) Golden Living Center			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 219-14-6113	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/04/1922	9. Birthplace (State or Foreign Country) West Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Allegany			10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1014 Van Buren Avenue			10f. Zip Code 21502			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Case Worker			16b. Kind of Business Industry Social Services			
	17. Father's Name (First, Middle, Last) Frank Clifford Turnley			18. Mother's Name (First, Middle, Maiden Surname) Gertrude Amelia Frazier					
	19a. Informant's Name/Relationship (Type, Print) Paul B. Gipe / Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Van Buren Avenue, Cumberland, MD 21502					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet Cem @ Rocky Gap			Date 08/11/2011		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502			20c. Location - City or Town, State Flintstone, MD		
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  <i>Dementia</i>							Approximate Interval Between Onset and Death <i>few years</i>	
	<p>a. Due to (or as a consequence of):  <i>Dementia</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Aortic Stenosis, Anemia</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D46346			29d. Date signed (Month, Day, Year) 8/8/11		
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD 21502								
	31. Date filed (Month, Day, Year) AUG 10 2011			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

*2*  
*Huma*  
State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28428

**1-** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department. If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		Lee Gaffney			2. Date of Death
Virginia					Month Day Year
					August 10, 2011
4a. Facility Name (if not institution, give street and number)		Cumberland			3. Time of Death
Western MD Regional Medical Center					1:29 AM
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth	
220-03-7682		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	90 Yrs.	Months	Days
				Hours	Min.
				(Month, Day, Year)	
				07/11/1921	
9. Birthplace (State or Foreign Country)		Maryland			
Usual Residence of Decedent		10d. Inside City Limits			
10a. State		10b. County	10c. City, Town or Location		
MD		Allegany	Cumberland		
10e. Street and Number		10f. Zip Code			10g. Citizen of What County?
640 Washington Street, Apt 3		21502			USA
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			Specify: White
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 3			Registered Nurse Nursing Home
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
George Arthur Wolford		Nellie Virginia Dean			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
James Gaffney / Husband		640 Washington Street, Apt 3, Cumberland, MD 21502			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Cumberland Crematory		08/11/2011	Cumberland, MD
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
<i>Helen Adams</i>		Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
Approximate Interval Between Onset and Death Few days					
a. <u>Anoxic Encephalopathy</u> Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
<i>Bethany 8/11/11</i>					
IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
S/P Left Hip Fracture					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death		28a. Date of Injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		08/05/2011	1900 PM	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Patient Fell
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 640 Washington St, Apt 3 Cumberland, MD 21502
29a. Certifier (Check only one)		29c. License number			29d. Date signed (Month, Day, Year)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		D46346			August 10, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD 21502					
31. Date filed (Month, Day, Year)		32. Registrar's Signature			
AUG 11 2011		<i>Laura J. Parker</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28429  
Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

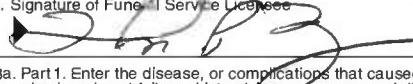
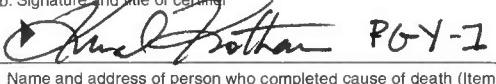
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<b>MARY JANE GOLDING</b>		AUGUST 12 2011				4:42 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<b>HARBOR HOSPITAL</b>		<b>BALTIMORE</b>				N/A	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-64-8986		78			Jan. 21, 1933	Scotland	
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Odenton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 190 Langdon Farm Circle			10f. Zip Code 21113			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Decedent's Usual Occupation Artist/Homemaker		16b. Kind of Business/Industry Art/Own Home	
17. Father's Name (First, Middle, Last) John Hill				18. Mother's Name (First, Middle, Maiden Surname) Catherine Donoughe			
19a. Informant's Name/Relationship (Type, Print) Linda C. Pattison / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190 Langdon Farm Circle, Odenton, MD 21113				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory			Date 8/16/2011	20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death
<p>a. <u>OVARIAN CANCER</u> Due to (or as a consequence of): <u>SEPTIC SHOCK</u></p> <p>b. Due to (or as a consequence of): <u>ACUTE RESPIRATORY DISTRESS SYNDROME</u></p> <p>c. Due to (or as a consequence of): <u>ACUTE KIDNEY FAILURE</u></p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION, DIABETES MELLITUS II, GASTRO-ESOPHAGEAL REFLUX DISEASE,</u>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  PGY-1		29c. License number RES 001			29d. Date signed (Month, Day, Year) AUGUST 12, 2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUNAL KOTHARI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225					
31. Date filed (Month, Day, Year) AUG 17 2011		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

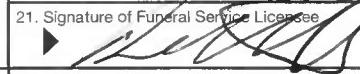
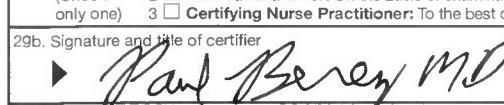
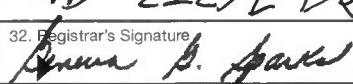
Reg. No. 2011 28430

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 5:00 PM
Ronald Harvey Galster, Sr.		August 11, 2011		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Crofton Convalescent & Rehab Center		Crofton		Anne Arundel
5. Social Security Number 313-40-0416 Usual Residence of Decedent		6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 3, 1940
10a. State Maryland		10b. County Prince George's	10c. City, Town or Location Bowie	9. Birthplace (State or Foreign Country) Indiana
10e. Street and Number 2605 Kenhill Drive		10f. Zip Code 20715		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Salesman		16b. Kind of Business/Industry Montgomery Wards
17. Father's Name (First, Middle, Last) Leo Galster		18. Mother's Name (First, Middle, Maiden Surname) Margery Ella Preble		
19a. Informant's Name/Relationship (Type, Print) Jeanne Galster/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Kenhill Drive Bowie, MD 20715		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		Date 8/18/2011
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715		20c. Location - City or Town, State Glen Burnie, MD
<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <i>Failure to thrive</i></p> <p>b. Due to (or as a consequence of): <i>Dementia</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 3 months</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><i>Cerebrovascular Disease</i> <i>Hemiplegia</i></p> <p>23e. Did tobacco use contribute to the cause of death?</p> <p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p>				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		<p>26. Place of Death (Check only one)</p> <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0029571		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 08/12/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul B. Berney MD 2225E Defense Hwy, Crofton, MD 21114</i>		32. Registrar's Signature 		
31. Date filed (Month, Day, Year) AUG 18 2011		33. Date of Report (Month, Day, Year)		

ORIGINAL

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28431

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rosa GUSEWICH</b>							2. Date of Death Month August Day 17 Year 2011	3. Time of Death 1:50 P M			
	4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>					
Funeral Director	5. Social Security Number <b>095-44-7440</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Feb. 7, 1922</b>	9. Birthplace (State or Foreign Country) <b>Poland</b>					
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Rockville</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>6111 Montrose Rd., #818</b>				10f. Zip Code <b>20852</b>			10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail Store Owner</b>			16b. Kind of Business Industry <b>Fabric</b>					
17. Father's Name (First, Middle, Last) <b>Tobias Buznicki</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Chava Graiser</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Miriam Gusevich, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3601 Connecticut Ave., #820, NW, Washington, DC 20008</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>			Date <b>08/19/11</b>	20c. Location - City or Town, State <b>Olney, MD</b>					
21. Signature of Funeral Director 			21. Signature of Funeral Director <b>M01008</b> Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012									
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death			
	<p>a. <b>Cardiorespiratory Arrest</b> Due to (or as a consequence of):</p> <p>b. <b>Metastatic Cholangiocarcinoma</b> Due to (or as a consequence of):</p> <p>c. <b>Hypotension</b> Due to (or as a consequence of):</p> <p>d. _____</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 								29c. License number <b>D 0055856</b> 29d. Date signed (Month, Day, Year) <b>08/17/11</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Negash Ayele, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910</b>												
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	
State Registrar	

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

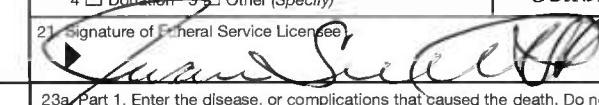
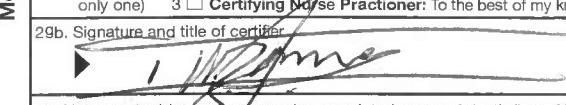
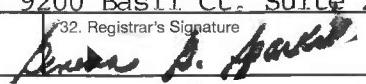
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28432

**1 - For State Registrar**

<b>Physician/ Medical Examiner</b>		1. Decedent's Name (First, Middle, Last) <b>Elba Martinez Garcia</b>								2. Date of Death Month <b>08</b> Day <b>12</b> Year <b>2011</b>		3. Time of Death <b>06:00 aM</b>			
		4a. Facility Name (if not institution, give street and number) <b>8101 Murray Hill Dr.</b>				4b. City, Town, or Location of Death <b>Fort Washington</b>				4c. County of Death <b>Prince George</b>					
<b>Funeral Director</b>		5. Social Security Number <b>592-54-8619</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81 Yrs.</b>		If Under 1 Year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		8. Date of Birth Month <b>10</b> Day <b>17</b> Year <b>1929</b>		9. Birthplace (State or Foreign Country) <b>Nicaragua</b>			
		Usual Residence of Decedent 10a. State <b>Md</b> 10b. County <b>Prince George</b> 10c. City, Town or Location <b>Fort Washington</b>								10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number <b>8101 Murray Hill Dr.</b>				10f. Zip Code <b>20744</b>				10g. Citizen of What Country? <b>Nicaragua</b>					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Nicaragua</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>							
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT Use retired) <b>Seamstress</b>				16b. Kind of Business Industry <b>Self Employed</b>					
		17. Father's Name (First, Middle, Last) <b>Jose Felix Garcia</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Manuela Martinez Sandino</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>Daisy Torres Garcia/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8101 Murray Hill Dr. Ft. Washington, Md 20744</b>									
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>General Cemetery</b>				Date <b>08/20/11</b>		20c. Location - City or Town, State <b>Nicaragua</b>			
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John T. Rhines Funeral Home 3005 12th. St. NE Washington D.C. 20017</b>									
<b>Physician/ Medical Examiner</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death					
		a. <i>Circumstances of Unknown Primary</i> Due to (or as a consequence of):													
		b. _____ Due to (or as a consequence of):													
		c. _____ Due to (or as a consequence of):													
		d. _____													
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month <b>0</b> Day <b>0</b> Year <b>0</b>							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 								29c. License number <b>D70102</b>		29d. Date signed (Month, Day, Year) <b>08-17-2011</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ivan Zama, M.D. 9200 Basil Ct. Suite 200, Largo, Md. 20774</b>													
		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature 											

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial record.

2

**State  
Registrar**

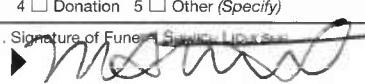
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2011 28433

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Paul Aime Gagnon</b>						2. Date of Death Month August Year 18, 2011	3. Time of Death 11:48 am
	4a. Facility Name (if not institution, give street and number) <b>Suburban Hospital</b>			4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>unk.</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>9/20/1932</b>	9. Birthplace (State or Foreign Country) <b>Canada</b>	
							10d. Inside City Limits <b>1 □ Yes 2 X No</b>	
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Kensington</b>			10e. Street and Number <b>10618 Parkwood Drive</b> 10f. Zip Code <b>20895</b> 10g. Citizen of What Country? <b>USA</b>				
<b>Physician/ Medical Examiner</b>	11. Marital Status <b>1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>White</b> Specify:	
<b>To Be Completed by Physician/Medical Examiner</b>	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 6</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Driver</b>			16b. Kind of Business Industry <b>Transportation</b>	
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	17. Father's Name (First, Middle, Last) <b>Josaphat Gagnon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Gauthier</b>			
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Yvon Gagnon, brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1264 Carswell Ave. Ste Foy, Quebec, Canada</b>			
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	20a. Method of Disposition <b>1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>8/20/2011</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>		
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Director 		22. Name and Address of Facility <b>Rapp Funeral &amp; Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910</b>					
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Massive Intracranial Hemorrhage Non-Traumatic</b>							
	Approximate Interval Between Onset and Death							
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	a. Due to (or as a consequence of): <b>Hypertension, chronic</b>							
	b. Due to (or as a consequence of):							
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 □ No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>				Date of delivery Month Day Year	
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>	
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	25. Was case referred to medical examiner? <b>1 X Yes 2 □ No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 X ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>					
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	27. Manner of Death <b>1 X Natural 5 □ Pending Investigation 2 □ Accident 3 □ Suicide 4 □ Homicide 6 □ Could not be determined</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	29a. Certifier <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D68405</b>					
			29d. Date signed (Month, Day, Year) <b>08/18/2011</b>					
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jesus Guevara-Nieto, MD; 8600 Old Georgetown Rd. Bethesda, MD 20815</b>							
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>	32. Registrar's Signature 						

Caglau, Paul  
Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trust.

18 AUG 11 @ 11:48 AM  
12

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Paul, Caglau**  
Division of Vital Records, P.O. Box 68760

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28434

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

12x  
MS

1. Decedent's Name (First, Middle, Last) <b>HARRY LOUIS GRIFFITH</b>		2. Date of Death Month Day Year <b>AUGUST 19 2011</b>		3. Time of Death 1:15 PM
4a. Facility Name (if not institution, give street and number) <b>CORSICA HILLS NURSING HOME</b>		4b. City, Town, or Location of Death <b>CENTREVILLE</b>		4c. County of Death <b>QUEEN ANNE'S</b>
5. Social Security Number <b>216-20-8313</b>	6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates. <b>1943-1946</b>	8. Date of Birth (Month, Day, Year) <b>06/04/1924</b>
9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>				
10a. State <b>MD</b>	10b. County <b>QUEEN ANNE'S</b>	10c. City, Town or Location <b>STEVENSVILLE</b>		10d. Inside City Limits 1 □ Yes 2 X No
10e. Street and Number <b>216 QUEEN ANNE ROAD</b>		10f. Zip Code <b>21666</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. <b>1943-1946</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: <i>White</i>	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business Industry <b>TOOL &amp; DIE MAKER</b>	16c. Kind of Business Industry <b>MANUFACTURING</b>	
17. Father's Name (First, Middle, Last) <b>LOUIS GRIFFITH</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>L. MAY FRANK</b>		
19a. Informant's Name/Relationship (Type, Print) <b>EILEEN FRANCES GRIFFITH /WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>216 QUEEN ANNE RD., STEVENSVILLE, MD 21666</b>		
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>STEVENSVILLE CEMETERY</b>	Date <b>08/23/2011</b>	20c. Location - City or Town, State <b>STEVENSVILLE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>Adult future to thrive weeks</i>		
b. Due to (or as a consequence of): <i>Deamia</i>		<i>years</i>		
c. Due to (or as a consequence of): <i>Cerebrovascular insufficiency</i>		<i>years</i>		
d. Due to (or, as a consequence of): <i>Atherosclerosis, generalized</i>		<i>years</i>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown		
		24a. Was an autopsy performed? 1 □ Yes 2 X No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 □ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)			
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>DLS933</b>		29d. Date signed (Month, Day, Year) <b>8/22/11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M.D. Crowley, MD 610 Dutchmans Lane, Easton, MD 21601</b>				
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature 		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28435

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Jacqueline Henderson</i>						2. Date of Death Month <i>August</i> Day <i>17</i> Year <i>2011</i>	3. Time of Death <i>10:25A M</i>
	4a. Facility Name (if not institution, give street and number) <i>2106 Oregon Avenue</i>			4b. City, Town, or Location of Death <i>Landover</i>			4c. County of Death <i>Prince George's</i>	
<b>Funeral Director</b>	5. Social Security Number <i>578-54-2630</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <i>70</i> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <i>09/14/1940</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>	
<b>To Be Completed by Funeral Director</b>	10a. State <i>MD</i> 10b. County <i>Prince George's</i> 10c. City, Town or Location <i>Landover</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>2106 Oregon Avenue</i>			10f. Zip Code <i>20785</i>			10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <input checked="" type="checkbox"/> Black Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Accountant</i>			16b. Kind of Business Industry <i>Dept. of Treasury</i>		
	17. Father's Name (First, Middle, Last) <i>Calvin McBride</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Bernice Witherspoon</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Natalie Henderson/Granddaughter</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2106 Oregon Avenue Landover, MD 20785</i>				
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lincoln Memorial</i>			Date <i>08/24/2011</i>	20c. Location - City or Town, State <i>Suitland, MD</i>	
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <i>Mahan Frederick</i>		22. Name and Address of Facility <i>Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746</i>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last							
	<p>a. <i>Breast Cancer</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D0057465</i>					
	29b. Signature and title of certifier <i>N. S. Rajapakse, M.D.</i>		29d. Date signed (Month, Day, Year) <i>8/18/11</i>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N. S. Rajapakse, M.D. 2835 Smith Av 5203 Baltimore MD 21209</i>							
	31. Date filed (Month, Day, Year) <i>AUG 22 2011</i>		32. Registrar's Signature <i>James D. Fahey</i>					

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registry Amend#10e.19b.PerFPGC8-24-11 Certificate of Death

2011 28436  
Reg. No.

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DARRYL ORLANDO HACKETT</b>					2. Date of Death Month <b>August</b> Day <b>14</b> Year <b>2011</b>	3. Time of Death 1935 M
	4a. Facility Name (if not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>			4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>	
<b>Funeral Director</b>	5. Social Security Number <b>579-64-1005</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month <b>08</b> Day <b>26</b> Year <b>1947</b>	9. Birthplace (State or Foreign Country) <b>DC</b>
Usual Residence of Decedent 10a. State <b>NC</b> 10b. County <b>Onslow</b> 10c. City, Town or Location <b>Jacksonville</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>223 Spruce Court</b>				10f. Zip Code <b>28546</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>20 yrs</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Drill Instructor</b>			16b. Kind of Business Industry <b>Government</b>	
17. Father's Name (First, Middle, Last) <b>Willie Hackett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Hinton</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Cynthia Hall Hackett/Wife</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Quantico National</b>			
				Date <b>08/24/2011</b>		20c. Location - City or Town, State <b>Triangle, VA</b>	
21. Signature of Funeral Service Licensee <b>Charles E. Herring</b>				22. Name and Address of Facility <b>Pope Funeral Homes, P.A.</b> <b>5538 Marlboro Pike, Forestville, MD 20747</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. <u>Hypertensive Arterosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): <u>Diabetes</u></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>DR. SANDRA BANKS</b>				29c. License number <b>D0062057</b>		29d. Date signed (Month, Day, Year) <b>08/14/2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. SANDRA BANKS, MD. 7503 Surratts Road, CLINTON, MARYLAND, 20735</b>							
31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>Jenny S. Harrel</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011

28437

1 - For State Registrar		Certificate of Death													
		Reg. No.													
<b>Physician/ Medical Examiner</b>  <b>Funeral Director</b>		1. Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death					
		Elsie Jane Hughes					Month	Day	Year	0340	M				
		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death						
		Western MD Regional Medical Center				Cumberland			Allegany						
		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)					
		215-18-8219		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	89 Yrs.	Months	Days	Hours	Min.	02/16/1922	Maryland				
		Usual Residence of Decedent													
		10a. State	10b. County	10c. City, Town or Location								10d. Inside City Limits			
		MD	Allegany	Cumberland								1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?					
		628 East First Street					21502			USA					
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.					
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White					
		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry					
		Elementary/Secondary (0-12) 8				College (1-4 or 5+) Homemaker				Home					
		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)								
		Harry W. Dickerhoof					Eva Inez Krimm								
		19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
		Frances Burdette / Daughter					628 East First Street, Cumberland, MD 21502								
		20a. Method of Disposition					20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State				
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					Mt. Olivet Cemetery			08/17/2011	Parkersburg, WV				
		21. Signature of Funeral Service Licensee					22. Name and Address of Facility								
		<i>John J. Adams</i>					Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502								
<b>Physician/ Medical Examiner</b>  <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
		Approximate Interval Between Onset and Death													
		Immediate Cause (Final disease or condition resulting in death)													
		<p>a. <i>Aspiration pneumonia</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>													
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
		IF FEMALE:													
		23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy						23d. Date of delivery					
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						Month	Day	Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
		<i>Lung mass</i>													
		<i>Esophageal dysmotility</i>													
		23e. Did tobacco use contribute to the cause of death?													
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
		24a. Was an autopsy performed?													
		24b. Were autopsy findings available prior to completion of cause of death?													
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
		25. Was case referred to medical examiner?													
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one)		Other:							
				1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
		27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work?		28d. Describe how injury occurred					
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number		29d. Date signed (Month, Day, Year)					
		<i>Christopher Vagnoni, M.D.</i>				70059987		8/14/2011							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
		Christopher Vagnoni, M.D., 12501 Willowbrook Road, Cumberland, MD 21502													
		31. Date filed (Month, Day, Year)		32. Registrar's Signature											
		AUG 15 2011		<i>Christy Vagnoni</i>											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28438

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

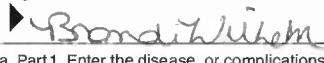
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death P 10:50M	
		Carl William Hausrath		August 19, 2011			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		Frostburg Village Nursing Home		Frostburg		Allegany	
Funeral Director		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) September 11, 1929	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent		10a. State Maryland		10b. County Allegany	
		10c. City, Town or Location		Lonaconing		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 15536 Lower Georges Creek Road, SW		10f. Zip Code 21539		10g. Citizen of What Country? USA	
Physician /Medical Examiner		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Laborer Glass	
		17. Father's Name (First, Middle, Last) Carl Lester Hausrath		18. Mother's Name (First, Middle, Maiden Surname) Mary Joseph Fair			
		19a. Informant's Name/Relationship (Type, Print) Gene Hausrath - Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16922 Dutch Hollow Road, NW, Mt. Savage, Maryland, 21545			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): Frostburg Memorial Park		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date August 23, 2011	20c. Location - City or Town, State Frostburg, Maryland
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 		Approximate Interval Between Onset and Death	
		23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year	
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D26907	
		29d. Date signed (Month, Day, Year) August 22, 2011		31. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harij Sidhu MD, 925 Bishopfish Road, Cumberland, Maryland, 21502		32. Registrar's Signature Clement J. Parker	
		31. Date filed (Month, Day, Year) AUG 22 2011		32. Registrar's Signature			

## Certificate of Death

Reg. No. 2011 28439

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <b>DOROTHY RUTH HARTMAN</b>				2. Date of Death Month 08 Day 05 Year 2011	3. Time of Death 2:13P.M.		
Physician/Medical Examiner		4a. Facility Name (if not institution, give street and number) <b>Devlin Manor Nursing Home</b>		4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>			
Funeral Director		5. Social Security Number <b>215-12-2087-214-05-4724-</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>08/07/1923</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>#1 Baltimore Street</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Counselor</b>		16b. Kind of Business Industry <b>Mental Health</b>			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Clarence Greene</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Mae Smith</b>				
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Michael L. Hartman, Sr. / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Walker Road, LaVale, MD 21502</b>					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Sunset Memorial Park</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>08/10/2011</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Henry V. Upchurch</b>		22. Name and Address of Facility <b>Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502</b>					
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CORONARY Artery Disease</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>year</b>	
To Be Completed by Physician/Medical Examiner		b. _____ Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner		c. _____ Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner		d. _____							
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fibrillation &amp; Advanced Dementia</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <b>Jesus Tan, M.D.</b>		29c. License number <b>D21244</b>		29d. Date signed (Month, Day, Year) <b>08/08/2011</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jesus Tan, M.D., 4 Broadway, Frostburg, MD 21532</b>							
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <b>AUG 09 2011</b>		32. Registrar's Signature <b>Jesus A. Tan</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28440

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darnell S. Holland</b>					2. Date of Death Month Aug. Day 13 Year 2011	3. Time of Death 2302 M
	4a. Facility Name (if not institution, give street and number) <b>Southern Maryland Hospital</b>			4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>214-58-4314</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>59 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Jul. 29, 1952</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>Owings</b>						10d. Inside City Limits <b>1 □ Yes 2 X No</b>
	10e. Street and Number <b>382 Skinners Turn Road</b>			10f. Zip Code <b>20736</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 □ No If Yes, Give Year or Dates.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Mail Clerk</b>		16b. Kind of Business Industry <b>Federal Government</b>		
	17. Father's Name (First, Middle, Last) <b>William Holland</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Cozzette Reed</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Cozzette Gray/mother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>382 Skinners Turn Rd. Owings, MD 20736</b>			
	20a. Method of Disposition <b>1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chelt. Vet. Cem.</b>	Date <b>8/24/2011</b>	20c. Location - City or Town, State <b>Cheltenham, MD</b>	
	21. Signature of Funeral Service Licensee <b>▶ Shadie A. Sewell</b>			22. Name and Address of Facility <b>Sewell Funeral Home, P.A. 1451 Dares Beach Rd. Prince Fred., MD 20678</b>			

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year	Approximate Interval Between Onset and Death		
{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown									
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown			
25. Was case referred to medical examiner? 1 □ Yes 2 X No		Hospital: 1 □ Inpatient 2 X ER/Outpatient 3 □ DCA		Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		24a. Was an autopsy performed? 1 □ Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 □ No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier <b>▶ William Carter, M.D.</b>		29c. License number <b>D0038384</b>				29d. Date signed (Month, Day, Year) <b>8/16/11</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Carter, M.D.</b>									
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature <b>▶ Shadie A. Sewell</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28441

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**Stacy Betha Holba**

2. Date of Death

Month August Day 11 Year 2011

3. Time of Death

2:10 PM

4a. Facility Name (if not institution, give street and number)

**5974 Hillside Road**

4b. City, Town, or Location of Death

**St. Leonard**

4c. County of Death

**Calvert**

5. Social Security Number

**042-28-8263**

6. Sex

M  F

7. Age (In yrs. last birthday)

**77**

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month Day Year

**11/19/1933**

9. Birthplace (State or Foreign Country)

**Grenada**

Usual Residence of Decedent

10a. State

**Maryland**

10b. County

**Calvert**

10c. City, Town or Location

**St. Leonard**

10d. Inside City Limits

Yes  No

10e. Street and Number

**5974 Hillside Road**

10f. Zip Code

**20685**

10g. Citizen of What Country?

**United States**

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give **X** Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.  
 Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) **8**

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**homemaker**

16b. Kind of Business Industry

**own home**

17. Father's Name (First, Middle, Last)

**unknown**

18. Mother's Name (First, Middle, Maiden Surname)

**Louise Winsborrow**

19a. Informant's Name/Relationship (Type, Print)

**Daniel Holba / Husband**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**5974 Hillside Road, St. Leonard, Maryland 20685**

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of Cemetery, crematory or other place)

**Asbury Cemetery**

Date

**August 15 2011**

20c. Location - City or Town, State

**Barstow Maryland**

21. Signature of Funeral Service Licensee

**DRausch**

22. Name and Address of Facility

**Rausch Funeral Home, PA.**

4405 Broomes Island Road, Port Republic, Maryland 20676

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

**Parkinsons**

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No

Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)

Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Hypotension**

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient  ER/Outpatient  DOA

Other:

Nursing Home  Residence  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

Natural

Pending Investigation

Accident

Suicide

Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

**DRausch**

29c. License number

**DO060535**

29d. Date signed (Month, Day, Year)

**8/12/11**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**110 Hospital Rd. Suite 310 Prince Fred. MD 20678**

31. Date filed (Month, Day, Year)

**AUG 15 2011**

32. Registrar's Signature

**Laura S. Parker**

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28442

1 - For  
State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Fred W. Holland</b>				2. Date of Death Month Day Year <b>August 8, 2011</b>		3. Time of Death 1945 M	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>216-30-4378</b>		6. Sex <b>1 X M</b>	7. Age (In yrs. last birthday) <b>78 Yrs.</b>	If Under 1 Year Months <b>01</b>	If Under 24 Hrs. Days <b>31</b>	8. Date of Birth (Month, Day, Year) <b>01/31/1933</b>	9. Birthplace (State or Foreign Country) <b>D.C.</b>
		Usual Residence of Decedent 10a. State <b>MD</b>				10b. County <b>Calvert</b>		10c. City, Town or Location <b>Sunderland</b>	
		10e. Street and Number <b>1615 Pushaw Station Rd.</b>				10f. Zip Code <b>20689</b>		10g. Citizen of What Country? <b>USA</b>	
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) <b>Electrician</b>		16b. Kind of Business Industry <b>D.C. Parks &amp; Recreation</b>			
		17. Father's Name (First, Middle, Last) <b>Carroll Holland</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Wilks</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Thelma Holland/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1615 Pushaw Sta. Rd. Sunderland, MD 20689</b>			
Physician/ Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Chelt. Vet. Cem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chelt. Vet. Cem.</b>		Date <b>8/18/2011</b>	20c. Location - City or Town, State <b>Cheltenham, MD</b>		
		21. Signature of Funeral Service Licensee <b>Blader A. Sewell</b>		22. Name and Address of Facility <b>Sewell Funeral Home, P.A. 1451 Dares Beach Rd. Prince Fred., MD 20678</b>					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPTIC SHOCK</b>				Approximate Interval Between Onset and Death			
		a. Due to (or as a consequence of): <b>CARDIAC ARRHYTHMIA</b>							
		b. Due to (or as a consequence of): <b>END STAGE RENAL DISEASE</b>							
		c. Due to (or as a consequence of): <b>ACUTE RESPIRATORY FAILURE</b>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>8/16/2011</b>		28b. Time of injury <b>M</b>	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Greenbelt, MD 20770</b>			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>MD 52855</b>		29d. Date signed (Month, Day, Year) <b>8-9-2011</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chandra S. Korapati, M.D.</b>							
		31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature <b>Chandra S. Korapati</b>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1

2011 28443

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Genevieve E. Hayes</b>						2. Date of Death Month <b>August</b> Day <b>15</b> Year <b>2011</b>	3. Time of Death <b>7:55 PM</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>936 Schooner Circle</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>142-16-4481</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>4/29/1922</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
		Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number <b>936 Schooner Circle</b>					10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>African America</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Specialist</b>			16b. Kind of Business Industry <b>US Government</b>				
		17. Father's Name (First, Middle, Last) <b>George W. Elam</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Whitford</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Clyde Turpin - Nephew</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>215 West Valle Del Oro Rd, Oro Valley, AZ 85737</b>							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Memorial Park</b>			Date <b>8/22/11</b>	20c. Location - City or Town, State <b>Falls Church, VA</b>			
21. Signature of Funeral Service Licensee <b>John M. Taylor</b>		22. Name and Address of Facility <b>147 Duke of Gloucester St, Annapolis, MD 21401</b>									
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>COPD</b>								Approximate Interval Between Onset and Death <b>4 yrs</b>	
		b. Due to (or as a consequence of): <b>ITDM</b>								<b>4 yrs</b>	
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____								23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Joleen Jackson MSN</b>		29c. License number <b>D30718</b>			29d. Date signed (Month, Day, Year) <b>8-17-2011</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joleen Jackson MSN 3003 1/2 Hwy 100 Annapolis, MD 21401</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature <b>Anna B. Parker</b>							

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attendant  
within 24 hours after death.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State AMEND#17perFH, 8/19/11; BMW, MOCO  
Registration AMEND#17perFH, 8/19/11; BMW, MOCO

Certificate of Death

Reg. No.

2011 28444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Hunt</b>				2. Date of Death Month August Day 16 Year 2011	3. Time of Death 22:48 M		
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>245 58-1686</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>77 70 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 10, 1940</b>	9. Birthplace (State or Foreign Country) <b>Bedford, NC</b>
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>Beltsville</b>		10d. Inside City Limits <b>1 Yes 2 No</b>		
	10e. Street and Number <b>11590 Old Baltimore Pike</b>		10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>1965 - 1970</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4or 5+) Truck Driver</b>		16b. Kind of Business/Industry <b>Private</b>			
	17. Father's Name (First, Middle, Last) <b>Nathan Hunt</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Perry</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>James Hunt Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3005 Bladensburg Rd NE, #904, Washington, DC 20008</b>		Date <b>Aug. 26, 2011</b>	20c. Location - City or Town, State <b>Washington, DC</b>		
Physician /Medical Examiner	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glenwood Cemetery</b>					
	21. Signature of Funeral Service Licensee <b>Nicole Biegel</b>		22. Name and Address of Facility <b>Genesis Crem. And Funeral Service</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cardiorespiratory Arrest</b>							
	a. Due to (or as a consequence of): <b>Arrhythmia</b>							
	b. Due to (or as a consequence of): <b>Acute Myocardial Infarction</b>							
	c. Due to (or as a consequence of): <b>Diabetes Mellitus Type II</b>							
	d. Due to (or as a consequence of):							
	23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure stage III Congestive Heart Failure Coronary Artery Disease</b>							
	23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>							
	24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>							
	26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
	27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4701 Randolph Rd #216, Rockville MD 20852</b>	
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>47867</b>		29d. Date signed (Month, Day, Year) <b>8/16/2011</b>			
	29b. Signature and title of certifier <b>Onay Juniga</b>		29c. License number <b>47867</b>		29d. Date signed (Month, Day, Year) <b>8/16/2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Onay Juniga 4701 Randolph Rd #216, Rockville MD 20852</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature <b>Suzanne J. Spiegel</b>					

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

4

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No. 2011 28445

**1 - For State Registrar**

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>Richard Hogue</b>				2. Date of Death Month Day Year <b>08/15/2011</b>	3. Time of Death M <b>8:05am</b>
4a. Facility Name (If not institution, give street and number) <b>Washington Adventist</b>				4b. City, Town, or Location of Death <b>Takoma</b>	
5. Social Security Number <b>247-27-9995</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>41</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>01/04/70</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
Usual Residence of Decedent 10a. State <b>Md</b> 10b. County <b>Baltimore</b>				10c. City, Town or Location <b>Dundalk</b>	
10e. Street and Number <b>6912 5th Ave</b>				10f. Zip Code <b>21222</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>2yrs</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Private</b>	
17. Father's Name (First, Middle, Last) <b>Walter Hogue</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlene Wright</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Walter Hogue Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6912 Fifth Ave Dundalk Maryland 21222</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Larry L. Hogue</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate Of Heaven</b>		Date <b>08/20/2011</b>	20c. Location - City or Town, State <b>Silver Spring, MD</b>
21. Signature of Funeral Service Licensee <b>Larry L. Hogue</b>				22. Name and Address of Facility <b>Shread Funeral Home &amp; Cremation 5732 Georgia Ave NW Washington, DC 20011</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): <b>ACUTE MYO CARDIAL INFARCTION</b>  b. Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b>  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DIABETES</b> <b>RENAL FAILURE</b>					
				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home, Carroll Avenue, Takoma Park, Maryland</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D40324</b>	
29b. Signature and title of certifier <b>Jodee</b>				29d. Date signed (Month, Day, Year) <b>AUGUST 16, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERRY JODEE, MD, FAAP 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND</b>					
31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature <b>Leanne S. Parker</b>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28446

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Division of Vital Records, P.O. Box 68760

10a. State 10b. County 10c. City, Town or Location

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

State  
Registrar

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>James Daniel HANNAN</b>			2. Date of Death Month <b>August</b> Day <b>20</b> , Year <b>2011</b>	3. Time of Death <b>1225 PM</b>
4a. Facility Name (if not institution, give street and number) <b>BrookeGrove Rehabilitation and Nursing Center</b>			4b. City, Town, or Location of Death <b>Sandy Spring</b>	
5. Social Security Number <b>579-48-1081</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>78</b>
			If Under 1 Year Months	If Under 24 Hrs. Hours Min.
			8. Date of Birth (Month, Day, Year) <b>July 24, 1933</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
Usual Residence of Decedent  10a. State <b>Maryland</b> 10b. County <b>Montgomery</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>900 South Belgrave Road</b>			10f. Zip Code <b>20902</b>	
10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1952-</b> If Yes, Give Year or Dates. <b>1954</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business Industry <b>Federal Government</b>
17. Father's Name (First, Middle, Last) <b>John Francis Hannan</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Arabella Brittain</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Catherine M. Dorsey/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>900 South Belgrave Road, Silver Spring, MD. 20902</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		Date <b>8/24/2011</b>
21. Signature of Funeral Service Licensee <b>Michael Stubbs</b>		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>		

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter the disease, or complications that contributed to the death but did not result in the underlying cause given in Part I. <b>Parkinson's disease; dementia</b>		Approximate Interval Between Onset and Death <b>months</b>
{		a. Due to (or as a consequence of): <b>metastatic carcinoma of the prostate</b>		
{		b. Due to (or as a consequence of):		
{		c. Due to (or as a consequence of):		
{		d. Due to (or as a consequence of):		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's disease; dementia</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D42046</b>		
29b. Signature and title of certifier <b>Dr. [Signature] attending physician</b>		29d. Date signed (Month, Day, Year) <b>August 22, 2011</b>		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Grace Brooke Huffman, M.D. 18100 Slade School Road Sandy Spring, Maryland 20860</b>		
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		
32. Registrar's Signature <b>[Signature]</b>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

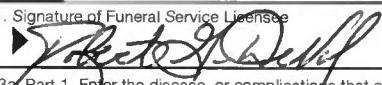
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28447

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Francis James Hefferon</b>				2. Date of Death Month Day Year <b>August 20, 2011</b>	3. Time of Death <b>10:53am M</b>	
	4a. Facility Name (if not institution, give street and number) <b>12433 St. James Road</b>				4b. City, Town, or Location of Death <b>Rockville</b>	4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>073-22-3533</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	
To Be Completed by Funeral Director	8. Date of Birth (Month, Day, Year) <b>April 8, 1928</b>				9. Birthplace (State or Foreign Country) <b>Massachusetts</b>		
	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Rockville</b>	
	10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						
	10e. Street and Number <b>12433 St. James Road</b>				10f. Zip Code <b>20850</b>	10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <b>Korea</b></b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b></b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 4 Petroleum Engineer</b>		16b. Kind of Business Industry <b>U.S. Government</b>		
	17. Father's Name (First, Middle, Last) <b>Frank Hefferon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Cullen</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Martha Hefferon (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12433 St. James Road, Rockville, MD 20850</b>		
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Metropolitan Crematory</b></b>				Date <b>8/21/2011</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>gastric cancer</b>						
	Approximate Interval Between Onset and Death <b>7 years</b>						
	23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>						
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) <b>9 <input type="checkbox"/> Unknown</b></b>						
	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic kidney disease coronary heart disease cerebrovascular disease</b>						
	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>						
	24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						
	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>						
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						
	26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>						
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>						
	28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>						
	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>						
	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>						
	29b. Signature and title of certifier <b>John R. Melnick MD</b>						
	29c. License number <b>D1929</b>						
	29d. Date signed (Month, Day, Year) <b>August 21, 2011</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John R. Melnick 911 Russell Ave Gaithersburg, Md. 20878</b>						
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>						
	32. Registrar's Signature <b>Leanne J. Parker</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

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To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

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Within 24 hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 28448  
Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Hsing Chich Huang</b>		2. Date of Death Month <b>August</b> Day <b>18</b> , Year <b>2011</b>	3. Time of Death <b>6:08a M</b>
4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>	
4c. County of Death <b>Montgomery</b>			
5. Social Security Number <b>124-46-1804</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months <b>09</b> Days <b>12</b> Hours <b>19</b> Min. <b>37</b>
8. Date of Birth (Month, Day, Year) <b>09/12/1937</b>		9. Birthplace (State or Foreign Country) <b>China</b>	
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>	
10c. City, Town or Location <b>Hyattsville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4800 Avondale Road</b>		10f. Zip Code <b>20782</b>	10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor</b>	16b. Kind of Business Industry <b>Education</b>
17. Father's Name (First, Middle, Last) <b>Ukn</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ukn</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Angie Chih Yuen Huang - Ex Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4800 Avondale Road, Hyattsville, Maryland 20782</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M01524</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cem</b>	Date <b>08/22/2011</b>
20c. Location - City or Town, State <b>Adelphi, Maryland</b>			
21. Signature of Funeral Service Licensee <b>M01524</b>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b> <b>11800 New Hampshire Ave., Silver Spring, MD 20904</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Days</b>	
a. <b>Sepsis</b> Due to (or as a consequence of):			
b. <b>Pneumonia</b> Due to (or as a consequence of):		<b>Days</b>	
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month <b>08</b> Day <b>18</b> Year <b>2011</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency</b> <b>Intra Abdominal Abscess</b> <b>Dementia</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0057630</b>	
29b. Signature and title of certifier <b>Anuradha Arun, M.D.</b>		29d. Date signed (Month, Day, Year) <b>08-18-2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anuradha, Arun, MD, 10301 Georgia Avenue, #209, Silver Spring, MD 20902</b>		31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>	
32. Registrar's Signature <b>Anuradha S. Arun</b>			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28449

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Teretha Hill		August 18, 2011		14:46 M	
4a. Facility Name (if not institution, give street and number) Montgomery General Hospital		4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number unk		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	
				8. Date of Birth (Month, Day, Year) 04/08/1947	9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent		10a. State unk 10b. County unk 10c. City, Town or Location unk			10d. Inside City Limits unk <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number unk		10f. Zip Code unk		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary to Director		16b. Kind of Business Industry Administration	
17. Father's Name (First, Middle, Last) John Hill		18. Mother's Name (First, Middle, Maiden Surname) Mary E. Brooks			
19a. Informant's Name/Relationship (Type, Print) Diana Osborne/sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Edna Avenue, Bridgeport, CT 06610			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Crematory		Date 08/24/2011	20c. Location - City or Town, State Bridgeport, CT
21. Signature of Funeral Service Licensee George R. Granda		22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850			
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death One Day			
a. <u>Pulmonary Embolism</u> Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D00 61604		29d. Date signed (Month, Day, Year) August 18, 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuanjue L. Zhang 10710 Charter Drive, #G020, Columbia, MD 21044					
31. Date filed (Month, Day, Year) AUG 23 2011		32. Registrar's Signature Lorraine J. Parker			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28450

1. For State Registrar		2. Date of Death Month Day Year				3. Time of Death			
Physician/ Medical Examiner		August 13, 2011				1:10 A M			
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Hebrew Home OF Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>			
		5. Social Security Number <b>084-10-4615</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 97 Yrs.			
		8. Date of Birth (Month, Day, Year) <b>11 / 15 / 1913</b>		9. Birthplace (State or Foreign Country) <b>Poland</b>		4c. County of Death <b>Montgomery</b>			
		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		10e. Street and Number <b>6121 Montrose Rd.</b>		10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business Industry <b>Typesetter</b>			
		17. Father's Name (First, Middle, Last) <b>Morris Hechtman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Heringer</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Carol Knoll -daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3278 Aberfoyle Pl. NW Washington, DC 20015</b>					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Kurt Blake</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>08/17/2011</b>		20c. Location - City or Town, State <b>Falls Church, VA</b>	
		21. Signature of Funeral Service Licensee <b>M01477</b>		22. Name and Address of Facility <b>Edward Sagel Funeral Direction Inc, 1091 Rockville Pike Rockville, MD 20852</b>					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>END STAGE DEMENTIA</b>		23c. Approximate Interval Between Onset and Death			
		23d. Due to (or as a consequence of): <b>ATHEROSCLEROSIS</b>		23e. Due to (or as a consequence of):					
		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):					
		23h. Due to (or as a consequence of):		23i. Due to (or as a consequence of):					
		23j. Due to (or as a consequence of):		23k. Due to (or as a consequence of):					
		23l. Due to (or as a consequence of):		23m. Due to (or as a consequence of):					
		23n. Due to (or as a consequence of):		23o. Due to (or as a consequence of):					
		23p. Due to (or as a consequence of):		23q. Due to (or as a consequence of):					
		23r. Due to (or as a consequence of):		23s. Due to (or as a consequence of):					
		23t. Due to (or as a consequence of):		23u. Due to (or as a consequence of):					
		23v. Due to (or as a consequence of):		23w. Due to (or as a consequence of):					
		23x. Due to (or as a consequence of):		23y. Due to (or as a consequence of):					
		23z. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
		23nn. Due to (or as a consequence of):		23oo. Due to (or as a consequence of):					
		23pp. Due to (or as a consequence of):		23qq. Due to (or as a consequence of):					
		23rr. Due to (or as a consequence of):		23ss. Due to (or as a consequence of):					
		23tt. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
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		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
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		23rr. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
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		23rr. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
		23nn. Due to (or as a consequence of):		23oo. Due to (or as a consequence of):					
		23pp. Due to (or as a consequence of):		23qq. Due to (or as a consequence of):					
		23rr. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
		23nn. Due to (or as a consequence of):		23oo. Due to (or as a consequence of):					
		23pp. Due to (or as a consequence of):		23qq. Due to (or as a consequence of):					
		23rr. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
		23nn. Due to (or as a consequence of):		23oo. Due to (or as a consequence of):					
		23pp. Due to (or as a consequence of):		23qq. Due to (or as a consequence of):					
		23rr. Due to (or as a consequence of):		23uu. Due to (or as a consequence of):					
		23vv. Due to (or as a consequence of):		23ww. Due to (or as a consequence of):					
		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
		23dd. Due to (or as a consequence of):		23ee. Due to (or as a consequence of):					
		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
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		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
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		23bb. Due to (or as a consequence of):		23cc. Due to (or as a consequence of):					
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		23ff. Due to (or as a consequence of):		23gg. Due to (or as a consequence of):					
		23hh. Due to (or as a consequence of):		23ii. Due to (or as a consequence of):					
		23jj. Due to (or as a consequence of):		23kk. Due to (or as a consequence of):					
		23ll. Due to (or as a consequence of):		23mm. Due to (or as a consequence of):					
		23nn. Due to (or as a consequence of):		23oo. Due to (or as a consequence of):					
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		23xx. Due to (or as a consequence of):		23yy. Due to (or as a consequence of):					
		23zz. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):					
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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28451

<b>Physician/ Medical Examiner</b>	1- For State Registrar							2. Date of Death Month Day Year			3. Time of Death 1419 hrs			
	1. Decedent's Name (First, Middle, Last) <b>Walter Clyde Huber</b>							August 14, 2011						
<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>2280 Bowersox Road</b>			4b. City, Town, or Location of Death <b>New Windsor</b>				4c. County of Death <b>Carroll</b>						
	5. Social Security Number <b>219-66-4467</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) <b>09/03/1954</b>	9. Birthplace (State or Foreign Country) <b>MD</b>						
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>New Windsor</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number <b>2280 Bowersox Road</b>			10f. Zip Code <b>21776</b>			10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year <b>1972</b> 1978		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plant Manager</b>				16b. Kind of Business/Industry <b>Custom Direct</b>					
	17. Father's Name (First, Middle, Last) <b>John William Huber, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Ruth Franklin</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Eleanor Huber/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>244 Sophia Avenue, Westminster, MD 21157</b>				Date <b>08/18/2011</b>					
<b>Physician /Medical examiner</b>	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>[Signature]</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens</b>			20c. Location - City or Town, State <b>Finksburg, MD</b>						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Pritts Funeral Home &amp; Chapel 412 Washington Road, Westminster, MD 21157</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Intraoral gunshot wound</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED										Approximate Interval Between Onset and Death			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
											24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene											
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Other (specify) 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>FOUND: Aug 14, 2011</b>		28b. Time of Injury <b>FOUND: 1407 hrs</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot self</b>					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Other (specify)</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2280 Bowersox Road, New Windsor, MD</b>					
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29b. Signature and title of certifier <i>[Signature]</i>								29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 15, 2011</b>	
	30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>													
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature <i>[Signature]</i>								OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28452

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<i>Joseph R Harley Sr.</i>		Month <i>8</i>	Day <i>13</i>	Year <i>11</i>
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Southern MD Hospital</i>		<i>Clinton</i>		<i>Prince George</i>
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)
<i>214-30-0706</i>		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	<i>77</i> Yrs.	Months <i>10</i> Days <i>21</i> Hours <i>1933</i> Min.
9. Usual Residence of Decedent		10. Inside City Limits		
<i>Maryland Prince George</i>		<i>Forestsille</i> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
<i>7816 Marlboro Pike</i>		<i>20747</i>		<i>USA</i>
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry
<i>Elementary/Seconday (0-12) 12</i>		<i>Truck Driver</i>		<i>Supermarket</i>
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		
<i>William W. Harley</i>		<i>Mary M Butler</i>		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
<i>Joseph R Harley Jr. - Son</i>		<i>1013 Red Brick Rd Garner N.C. 27529</i>		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		<i>Resurrection Cem</i>		<i>8-25-11</i>
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		
<i>Theresa Neal</i>		<i>Adams Funeral Home Ps, Agincourt MD 20008</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <i>Massive Myocardial Infarction</i>				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>C. McDonald</i>		29c. License number <i>DD064055</i>		29d. Date signed (Month, Day, Year) <i>08/18/11</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
<i>Eric McDonald 7503 Surratts rd. Clinton Md 20735</i>				
31. Date filed (Month, Day, Year)		32. Registrar's Signature		
<i>AUG 22 2011</i>		<i>Laura S. Jones</i>		

ORIGINAL

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2011 28453

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

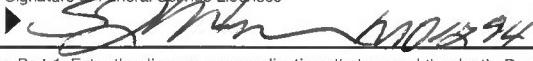
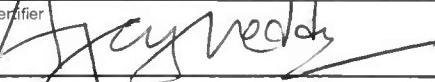
Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial record.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lyle V. Irvine</b> <b>Lyle Virginia Irvine</b>		2. Date of Death Month <b>Aug</b> Year <b>13, 2011</b>	3. Time of Death 4:45a M
4a. Facility Name (if not institution, give street and number) <b>Suburban Hospital</b>		4b. City, Town, or Location of Death <b>Bethesda</b>	4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>402-38-4550</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months <b>1</b> Days <b>14</b> Hours <b>24</b> Min. <b>0</b>
8. Date of Birth (Month, Day, Year) <b>11/29/1926</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>	
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Chevy Chase</b>
10e. Street and Number <b>8700 Jones Mills Road</b>		10f. Zip Code <b>20815</b>	10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>Year</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Caucasian</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	16b. Kind of Business Industry <b>Federal Aviation Administration</b>
17. Father's Name (First, Middle, Last) <b>Joseph Irvine</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Noel Jeffers</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Bruce D. Irvine - Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 Country Lane, Frankfort, Kentucky 40601</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ft. Lincoln Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>	Date <b>08/25/2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b> <b>11800 New Hampshire Ave., Silver Spring, MD 20904</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
Immediate Cause (Final disease or condition resulting in death)			
<p>a. <b>Cholecystitis</b> Due to (or as a consequence of):</p> <p>b. <b>Urinary Tract Infection</b> Due to (or as a consequence of):</p> <p>c. <b>Sepsis</b> Due to (or as a consequence of):</p> <p>d. <b>Acute Renal Failure</b></p>			
Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month <b>08</b> Day <b>25</b> Year <b>2011</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
<p><b>Atrial Fibrillation</b></p> <p><b>Dementia</b></p> <p><b>Congestive Heart Failure</b></p>			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
		29c. License number <b>D53691</b>	29d. Date signed (Month, Day, Year) <b>August 17, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ajay Reddy, LLC, 3200 Tower Oaks Blvd., #110, Rockville, Maryland 20852</b>			
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28454

3. Time of Death

Month Day Year

08 17 2011

12201A M

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death	
<b>KATHLEEN L. JENKINS</b>		Month	Day
		Year	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	
<b>Mandrin Chesapeake Hospice House</b>		<b>Harwood</b>	
4c. County of Death		4d. Date of Birth	
<b>Anne Arundel</b>		Month	Day
		Year	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)
216-36-4025		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	90 Yrs.
8. Date of Birth		9. Birthplace (State or Foreign Country)	
11-06-1920		<b>Maryland</b>	
10a. State		10b. County	10c. City, Town or Location
MD		Calvert	Dunkirk
10e. Street and Number		10f. Zip Code	
1485 Jewell Road		20754	
10g. Citizen of What Country?		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
15. Decedent's Education (Specify only highest grade completed)		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
Elementary/Secondary (0-12) 10		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry	
College (1-4 or 5+)		Payroll Clerk DC Govt. Public Works	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
Daniel Hardesty		Mollie Drury	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Janet L. Machado, daughter		1471 Jewell Road, Dunkirk, MD 20754	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		So. Mem. Gardens	08-20-2011
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
Immediate Cause (Final disease or condition resulting in death) <b>CVA</b>			
Approximate Interval Between Death and Death <b>2 days</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			
<p>a. Due to (or as a consequence of) <b>ATN</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>MANDRIN HOUSE</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier	
		29c. License number <b>021438</b>	29d. Date signed (Month, Day, Year) <b>August 17 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<b>MICHAEL J. LAPENTA MD 445 Defense Hwy Annapolis MD 21401</b>	
31. Date filed (Month, Day, Year)		32. Registrar's Signature <b>AUG 18 2011 ► Dennis A. Parker</b>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28455

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Francis P. Jackman		August 14, 2011		11:54 AM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
University of Maryland Hospital		Baltimore		Massachusetts
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)
024-24-0861		XX M 2 <input type="checkbox"/> F	79 Yrs.	3/13/1932
9. Birthplace (State or Foreign Country)		10d. Inside City Limits		
Massachusetts		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Usual Residence of Decedent				
10a. State	10b. County	10c. City, Town or Location		10d. Inside City Limits
Maryland	Anne Arundel	Annapolis		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
311 McDonough Road		21401		United States
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1953-1955		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry
Elementary/Secondary (0-12)		College (1-4 or 5+)		Newspaper
4		Newspaper Editor		
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		
Michael Jackman		Dianne Lemoine		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Jane Jackman/Wife		311 McDonough Road, Annapolis, MD 21401		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Date - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		St. Mary's Cemetery		8/20/2011 Annapolis, MD
21. Signature of Funeral Service Licensee		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401		
► Myrlin T. Klobart				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
Traumatic Brain Injury due to fall				
a. Due to (or as a consequence of):				
b. Due to (or as a consequence of):		CERTIFICATION APPROVED BY MEDICAL EXAMINER		
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		8/12/2011	10:00 PM	28d. Describe how injury occurred Fall
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) Home Annapolis, Maryland		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier ► D. Clark MD		29c. License number 101109		29d. Date signed (Month, Day, Year) 8/14/11
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
Damon Clark 22 South Greene St Baltimore, MD				
31. Date filed (Month, Day, Year) AUG 18 2011		32. Registrar's Signature Suzanne B. Parks		

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

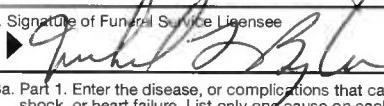
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28456

1- For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack JACOBS</b>						2. Date of Death Month Day Year <b>August 17, 2011</b>	3. Time of Death 8:45 P.M.		
	4a. Facility Name (if not institution, give street and number) <b>Renaissance Gardens</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Prince Georges</b>			
Funeral Director	5. Social Security Number <b>158-07-7197</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1920</b>	9. Birthplace (State or Foreign Country) <b>Hackensack, NJ</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Prince Georges</b> 10c. City, Town or Location <b>Silver Spring</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>3160 Gracefield Rd.</b>			10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business Industry <b>Mortgage Industry</b>			
	17. Father's Name (First, Middle, Last) <b>Israel Jacobs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Levine</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lawrence Jacobs / son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14346 Chesterfield Rd., Rockville, MD 20853</b>						
Physician/ Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Beth El Cemetery</b>			Date <b>Aug. 19, 2011</b>	20c. Location - City or Town, State <b>Township of Washington New Jersey</b>			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Deaths 1 month	
	a. Due to (or as a consequence of): <b>Failure to thrive</b>								3 years	
	b. Due to (or as a consequence of): <b>ASCV</b>								1 year	
	c. Due to (or as a consequence of): <b>Chronic Kidney Disease</b>									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)			<b>assisted living</b>	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 		29c. License number <b>R112633</b>			29d. Date signed (Month, Day, Year) <b>8/18/11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Julaine Harding, CNP 3160 Gracefield Rd., Silver Spring, MD 20904</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial form.

6+1

Amended Item #4c  
per physician;  
08/24/11, cs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28457

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Melinda Alwida Jones</i>					2. Date of Death Month Day Year <i>August 22 2011</i>	3. Time of Death 6:25 AM
	4a. Facility Name (If not institution, give street and number) <i>Garrett County Mem. Hospital</i>		4b. City, Town, or Location of Death <i>Oakland</i>			4c. County of Death <i>Maryland</i>	GARRETT
Funeral Director	5. Social Security Number <i>216-22-6580</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (If yrs. last birthday) <i>85</i> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <i>05 17 1926</i>	9. Birthplace (State or Foreign Country) <i>MD</i>		
	Usual Residence of Decedent  10a. State <i>MD</i>		10b. County <i>Garrett</i>	10c. City, Town or Location <i>Kitzmiller</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <i>PO Box 526</i>			10f. Zip Code <i>21538</i>	10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status  <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) <i>10</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <i>homemaker</i>	16b. Kind of Business/Industry  <i>own home</i>		
	17. Father's Name (First, Middle, Last) <i>Walter Leo Willis</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Vernia May Tasker</i>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Daniel James-son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>274 W. Main St., Kitzmiller, MD 21538</i>			
	20a. Method of Disposition  <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Kalbaugh Cemetery</i>			20b. Place of Disposition (Name of cemetery, crematory or other place)  <i>Kalbaugh Cemetery</i>	Date <i>8/24/2011</i>	20c. Location - City or Town, State <i>Elk Garden, WV</i>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  <i>David A Burdock</i>			22. Name and Address of Facility  <i>David A. Burdock Funeral Home P.A. 21 N 2nd St., Oakland, MD 21550</i>	Approximate Interval Between Onset and Death  <i>one day</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  <i>Cardiac arrhythmia</i>			23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <i>Myocardial infarction</i>			23c. If yes, outcome of pregnancy  <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death?  <i>Achalasia</i>			 <i>pneumonia</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one)  <i>Hospital</i>				
27. Manner of Death  <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  <i>At home</i>			28f. Location (Street and Number or Rural Route Number, City or Town, State)  <i>Oakland, Maryland 21550</i>				
29a. Certifier (Check only one)  <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number  <i>D47925</i>			29d. Date signed (Month, Day, Year)  <i>8/22/2011</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <i>Charles A. Welch</i>			31. Date filed (Month, Day, Year)  <i>AUG 23 2011</i>				
32. Registrar's Signature  <i>Sandra S. Parker</i>			33. Date signed (Month, Day, Year)  <i>8/22/2011</i>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans-

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28458

1. For State  
Registrar**Physician/  
Medical Examiner**

Reg. No.

1. Decedent's Name (First, Middle, Last)

Paul Joop

2. Date of Death

Month

Day

Year

August 16, 2011

3. Time of Death

0719 hrs

**Funeral  
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 2a or 2b show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

1. For State Registrar		1. Decedent's Name (First, Middle, Last)  Paul Joop						2. Date of Death Month Day Year August 16, 2011		3. Time of Death 0719 hrs			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) 1064 Tudor Drive			4b. City, Town, or Location of Death Crownsville			4c. County of Death Anne Arundel					
Funeral Director		5. Social Security Number 216-74-7216		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (MM/DD/YYYY) 11/16/1956			
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) Illinois											
		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crofton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		10e. Street and Number 1742 Remington Ct.			10f. Zip Code 21114			10g. Citizen of What Country? USA					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1 Subcontractor			16b. Kind of Business/Industry Home Improvements					
		17. Father's Name (First, Middle, Last) Glenn R. Joop			18. Mother's Name (First, Middle, Maiden Surname) Irene K. Kane								
		19a. Informant's Name/Relationship (Type, Print) Pamela J. Joop / Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1742 Remington Ct., Crofton, MD 21114								
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify			20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem. Gards.			Date 8/18/2011		20c. Location - City or Town, State Davidsonville, MD			
		21. Signature of Funeral Service Licensee  <i>[Signature]</i>			22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715								
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):						Approximate Interval Between Onset and Death					
		b. Hanging Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.											
		<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: Aug 16, 2011		28b. Time of Injury FOUND: 0709 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject found hanging			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. Yard						28f. Location (Street and Number or Rural Route Number, City or Town, State) 1064 Tudor Drive, Crownsville, MD					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier  <i>Ana Rubio MD</i>						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 17, 2011			
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
		31. Date filed (Month, Day, Year) AUG 19 2011						32. Registrar's Signature <i>Anne S. Parker</i>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ED  
5

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 28459

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>DOROTHY MARION JONES</b>		2. Date of Death Month Day Year <b>AUG. 16 2011</b>	3. Time of Death <b>4:21 p<sup>M</sup></b>
4a. Facility Name (If not institution, give street and number) <b>9917 North School Road</b>		4b. City, Town, or Location of Death <b>Deal Island</b>	
4c. County of Death <b>Somerset</b>		4d. Date of Birth (Month, Day, Year) <b>Feb. 14, 1928</b>	
5. Social Security Number <b>214-30-7936</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83 Yrs.</b>
8. If Under 1 Year Months 9. If Under 24 Hrs. Days Hours Min.		10. City, Town or Location <b>Deal Island</b>	
11. Usual Residence of Decedent <b>Md. Somerset</b>		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>	
16b. Kind of Business/Industry <b>Social Services</b>		17. Father's Name (First, Middle, Last) <b>Francis L. Griffiths</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Phyllis Cole</b>		19a. Informant's Name/Relationship (Type, Print) <b>Michael Jones- Son</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23257 East School Rd., Deal Island, Md. 21821</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Salisbury Crematory</b>	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>08/22/11</b>	20c. Location - City or Town, State <b>Salisbury, Md.</b>
21. Signature of Funeral Service Licensee <b>Jane J. M00295</b>		22. Name and Address of Facility <b>Hinman Funeral Home 11673 Somerset Ave. Princess Anne, Md. 21853</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
a. Due to (or as a consequence of): <b>adenocarcinoma of lung</b>		b. Due to (or as a consequence of): <b>liver metastasis</b>	
c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Describe how injury occurred	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>1 □ Yes 2 □ No</b> 28c. Injury at Work? <b>1 □ Yes 2 □ No</b> 28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>30134 mt Vernon rd PA md 21853</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>06159931</b>	
29d. Date signed (Month, Day, Year) <b>8/18/14</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles B. Hinman</b>		31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>	
32. Registrar's Signature <b>Leanne A. Parker</b>			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28460

1- For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Milton F. Johnson, Jr.</b>				2. Date of Death Month <b>August</b> Day <b>16</b> , Year <b>2011</b>	3. Time of Death <b>4:15p M</b>			
	4a. Facility Name (if not institution, give street and number) <b>209 Adclare Road</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>				
<b>Funeral Director</b>	5. Social Security Number <b>215-26-0353</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months <b>1947-</b>	If Under 24 Hrs. Hours <b>1950</b>	8. Date of Birth (Month, Day, Year) <b>May 01, 1931</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Worcester</b> 10c. City, Town or Location <b>Berlin</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>#2 Fort Sumter South</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>1947-1950</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>			16b. Kind of Business Industry <b>Photography</b>			
	17. Father's Name (First, Middle, Last) <b>Milton Frederick Johnson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Frances Killigan</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Milton F. Johnson - Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>209 Adclare Road, Rockville, Maryland 20850</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mo 1524</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		Date <b>08/19/2011</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>► Andrew Wong Mo 1524</b>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b> <b>11800 New Hampshire Ave., Silver Spring, MD 20904</b>						
<b>Physician/ Medical Examiner</b>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death	
	<p>a. <b>Metastatic Prostate Cancer</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke</b>								
								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Son's Home</b>						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier <b>► Andrew Wong</b>		29c. License number <b>D66066</b>		29d. Date signed (Month, Day, Year) <b>8/19/11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Wong, M.D., 6000 Executive Blvd., #625, N. Bethesda, Maryland 20852</b>								
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>Debra J. Parker</b>						

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tray.

15+1

The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tray.

15+1

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28461

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen Marie Jones

2. Date of Death

Month

Day

Year

AUGUST 14, 2011

3. Time of Death

4:00 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

220-62-1672

6. Sex

M  F

7. Age (in yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

June 10, 1953

9. Birthplace (State or Foreign Country)

New Jersey

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 2r is marked other than "natural", or items 2sa or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Usual Residence of Decedent

10a. State PA

10b. County Adams County

10c. City, Town or Location Abbottstown

10d. Inside City Limits  
 Yes  No

10e. Street and Number  
347 Bair Road

10f. Zip Code  
17301

10g. Citizen of What Country?  
USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Horse Trainer

16b. Kind of Business Industry  
Equine

17. Father's Name (First, Middle, Last)

Charles E. Byers

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Klaus

19a. Informant's Name/Relationship (Type, Print)

Kenneth I. Jones

Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

347 Bair Road, Abbottstown, PA 17301

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kenworthy Funeral Home, Inc. 08/16/2011

Date

20c. Location - City or Town, State

Hanover, PA

21. Signature of Funeral Service Licensee



CC0354

22. Name and Address of Facility

Kenworthy Funeral Home, Inc.

269 Frederick Street, Hanover, PA 17331

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CARDIAC ARREST  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

b. DIABETES  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify) \_\_\_\_\_  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
 Yes  No  Probably  Unknown

25. Was case referred to medical examiner?  
 Yes  No

Hospital:

Inpatient  ER/Outpatient  DOA

Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  


29c. License number

H58708

29d. Date signed (Month, Day, Year)

August 15, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEAL R. FRANKEL, D.O. 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 16 2011

32. Registrar's Signature



WIL  
16

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28462  
Reg. No.1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)

Audrey A. Keller

2. Date of Death  
Month Day Year  
August 18, 2011 4:49 PM

3. Time of Death

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

220-30-4255

6. Sex

 M  F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

Jan 15, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

 Yes  No

10e. Street and Number

2750 Duvall Road

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

 Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

 Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) Homemaker

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Audrey Stack

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Murphy

19a. Informant's Name/Relationship (Type, Print)

Charles V. Keller, Jr./husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2750 Duvall Road Woodbine, Maryland 21797

20a. Method of Disposition

 Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Michaels Poplar Springs

Date 8/20/2011

20c. Location - City or Town, State

Mt. Airy, MD

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

months

Colon Cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Unknown  Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

 Yes  No  Probably  Unknown

24a. Was an autopsy performed?

 Yes  No

24b. Were autopsy findings available prior to completion of cause of death?

 Yes  No

25. Was case referred to medical examiner?

 Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOAOther:  Nursing Home  Residence  Other (Specify) Hospice

27. Manner of Death

 Natural  
 Accident  
 Suicide  
 Homicide5  Pending Investigation  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

28c. Injury at work?

 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

KATHRYN BLACKFORD CRNP

29c. License number

R047324

29d. Date signed (Month, Day, Year)

August 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHRYN BLACKFORD CRNP 6334 Cedar LANE Columbia, MD 21044

31. Date filed (Month, Day, Year)

AUG 22 2011

32. Registrar's Signature

Anna S. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28463

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen S. King</b>							2. Date of Death Month <b>8</b> Day <b>18</b> Year <b>2011</b>	3. Time of Death <b>0836 AM</b>	
	4a. Facility Name (if not institution, give street and number) <b>Western MD Regional Medical Center</b>				4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>224-24-0973</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>July 20, 1918</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
	Usual Residence of Decedent <b>Maryland</b>		10a. State <b>Allegany</b>		10c. City, Town or Location <b>Mount Savage</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>12911 Brick Yard Row, N.W.</b>				10f. Zip Code <b>21545-</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>1</b>		16b. Kind of Business Industry <b>homemaker</b>					
	17. Father's Name (First, Middle, Last) <b>John Charles Spindler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Suzie Heavener</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>John King</b> son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12911 Brickyard Rd Mount Savage Maryland 21545-</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Saint Patrick's Cemetery</b>			Date <b>August 22, 2011</b>	20c. Location - City or Town, State <b>Mount Savage Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>								Approximate Interval Between Onset and Death <b>1 day</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	a. Due to (or as a consequence of): <b>Pneumonia</b>									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 								29c. License number <b>D0033280</b>	
	29d. Date signed (Month, Day, Year) <b>Aug 18, 2011</b>									
	29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sunil Gupta MD 635 Kent AVE Cumberland MD 21502</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature <b>Jessica P. Parker</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician/  
Medical Examiner**

**Funeral  
Director**

Baltimore, MD 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical  
xaminer**

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28464

**1- For State  
Registrar**

1. Decedent's Name (First, Middle, Last) <b>Betsy Ann Kupec</b>			2. Date of Death Month Day Year <b>August 21, 2011</b>			3. Time of Death <b>1734 hrs</b>
4a. Facility Name (if not institution, give street and number) <b>Calvert Memorial Hospital</b>			4b. City, Town, or Location of Death <b>North Beach Prince Frederick</b>			4c. County of Death <b>Calvert</b>
5. Social Security Number <b>226-04-5455</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>50 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
8. Date of Birth (MM/DD/YYYY) <b>07/02/1961</b>						9. Birthplace (State or Foreign Country) <b>KS</b>
Usual Residence of Decedent						
10a. State <b>MD</b>	10b. County <b>Calvert</b>	10c. City, Town or Location <b>North Beach</b>				10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
10e. Street and Number <b>9019 Chesapeake Avenue</b>			10f. Zip Code <b>20714</b>			10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>			16b. Kind of Business/Industry <b>Food Service</b>
17. Father's Name (First, Middle, Last) <b>Edward Walter Kupec</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Ann Bigelow</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charles Patrick Hanson/Friend</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 942, North Beach, MD 20714</b>			
20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Gary J. Goff</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Date <b>08/26/2011</b>	20c. Location - City or Town, State <b>Clinton, MD</b>
21. Signature of Funeral Service Licensee <b>Gary J. Goff</b>			22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
a. <b>Bupropion Intoxication</b> Due to (or as a consequence of):						
b. _____ Due to (or as a consequence of):						
c. _____ Due to (or as a consequence of):						
d. _____						
<b><input checked="" type="checkbox"/> UNPENDED</b> <b><input checked="" type="checkbox"/> AMENDED 4b, 26, per me, g919 9-9-11 sm 23a, 27, 28a-f, per me, g919 9-9-11 sm</b>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>						
24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			
25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene				
27. Manner of Death <b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>fd 8-21-11</b>	28b. Time of Injury <b>fd 4:30 pm</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Unknown</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>Fd: Residence</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>9019 Chesapeake Ave. Apt. #16 North Beach, Md.</b>	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <b>Wm. A. V.</b>			29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 22, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>						
31. Date filed (Month, Day, Year) <b>AUG 26 2011</b>		32. Registrar's Signature <b>Barbara S. Goff</b>				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28465

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

		1. Decedent's Name (First, Middle, Last) <b>CHARLES M. LAVIN</b>			2. Date of Death Month <b>AUGUST</b> Day <b>20</b> Year <b>2011</b>	3. Time of Death <b>8:05 AM</b>		
		4a. Facility Name (if not institution, give street and number) <b>HARFORD MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>HAVRE DE GRACE</b>			
		5. Social Security Number <b>185-07-2077</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months      Days      Hours      Min.	8. Date of Birth (Month, Day, Year) <b>OCT 10, 1916</b>	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
		Usual Residence of Decedent 10a. State <b>PENNSYLVANIA</b> 10b. County <b>DELAWARE</b>			10c. City, Town or Location <b>EDDYSTONE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>1255 EAST 11TH STREET</b>			10f. Zip Code <b>19022</b>	10g. Citizen of What Country? <b>UNITED STATES</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) FOREMAN</b>	16b. Kind of Business Industry <b>STEEL</b>				
		17. Father's Name (First, Middle, Last) <b>MICHAEL LAVIN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CONROY</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>MICHELE DOUGHER (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>192 BLYTHEDALE ROAD, PERRYVILLE, MARYLAND 21903</b>				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>LAWNCROFT CEMATION SERV</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LAWNCROFT CEMATION SERV</b>	Date <b>8/23/11</b>	20c. Location - City or Town, State <b>LINWOOD, PA</b>		
		21. Signature of Funeral Service Licensee <b>Dese Jett-Collman</b>		22. Name and Address of Facility <b>MCCAUSLAND-GARRITY FUNERAL HOME 202 S. CHESTER PIKE, GLENOLDEN, PA 19036</b>				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
		<p>a. Due to (or as a consequence of): <b>Non resolving pneumonia</b></p> <p>b. Due to (or as a consequence of): <b>pneumonia</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month      Day      Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
		29b. Signature and title of certifier <b>D. Jett</b>		29c. License number <b>DCe3072</b>			29d. Date signed (Month, Day, Year) <b>8/20/11</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anne Desar</b>		31. Date filed (Month, Day, Year) <b>AUG 23 2011</b> 32. Registrar's Signature <b>Reverend D. Jett</b>				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28466

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death			
Hazel Lucille Loughmiller			August 16, 2011			5:15 P M			
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
Morningside House Asst. Living			Waldorf			Charles			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year		8. Date of Birth		9. Birthplace (State or Foreign Country)
311-20-8915		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	87 Yrs.		Months	Days	Hours	Min.	03/13/1924 Indiana
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location							
Maryland	Charles	Waldorf							
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
70 Village Street			20602			USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry				
Elementary/Seconday (0-12) 12th		College (1-4 or 5+) Homemaker			In Home				
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
John Kiger				Hallie Bruce					
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Clair M. Loughmiller, Jr. // Son			9703 Indian Princess Dr. Ft. Washington, MD 20744						
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			Maryland Vet. Cemetery			8/24/2011	Cheltenham, Maryland		
21. Signature of Funeral Service Licensee			22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745						

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		
a. Due to (or as a consequence of): <i>Myocardial Infarction</i>		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

IF FEMALE:		23b. Was decedent pregnant in the past 12 months?			23c. If yes, outcome of pregnancy			23d. Date of delivery		
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No g <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						Month	Day	Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?				
					1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				

25. Was case referred to medical examiner?		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)					
				Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Assisted Liv. Ctr.</i>					
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number		29d. Date signed (Month, Day, Year)	
29b. Signature and title of certifier <i>James Harring MD</i>		00052919		8/18/11	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		32. Registrar's Signature	
<i>James Harring 201 Centennial ST La Plata MD 20646</i>		<i>James J. Pace</i>	
31. Date filed (Month, Day, Year)		32. Registrar's Signature	
AUG 22 2011			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28467

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Evelyn Ledbetter</i>				2. Date of Death Month <input type="text"/> 08 Day <input type="text"/> 11 Year <input type="text"/> 2011	3. Time of Death <input type="text"/> 0304 A M						
	4a. Facility Name (if not institution, give street and number) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGE'S</b>							
<b>Funeral Director</b>	5. Social Security Number <b>243-82-7845</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) <b>May 29, 1946</b>	9. Birthplace (State or Foreign Country) <b>DC</b>					
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Forestville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>6413 Pennsylvania Ave., #8</b>			10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>United States</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Secretary</b>		16b. Kind of Business Industry <b>Private</b>							
	17. Father's Name (First, Middle, Last) <b>Jacob David Lyles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pansy D. Wiggins</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Jacqueline Ledbetter/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6413 Pennsylvania Ave., #203 Forestville, MD 20747</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Karen G. Lyles 08/26/11</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>08/26/2011</b>	20c. Location - City or Town, State <b>Suitland, MD</b>						
	21. Signature of Funeral Service Licensee <i>Karen G. Lyles 08/26/11</i>		22. Name and Address of Facility <b>Pope Funeral Homes, P.A.</b> <b>5538 Marlboro Pike, Forestville, MD 20747</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Acute Renal Failure</i>							Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): <i>Advanced Stage of Cancer</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>				23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Wee Cee. MD</i>		29c. License number <b>D68315</b>		29d. Date signed (Month, Day, Year) <b>08/11/2011</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wee Cee. 3001 HOSPITAL DRIVE, CHEVERLY, MD.</b>							31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>			32. Registrar's Signature <i>James B. Farrel</i>		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28468

1 For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

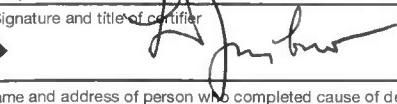
1. Decedent's Name (First, Middle, Last) <b>Ellen Mae Leasure</b>			2. Date of Death Month <b>August</b> Day <b>20</b> , Year <b>2011</b>	3. Time of Death 12:10 P M
4a. Facility Name (if not institution, give street and number) <b>Golden Living Center</b>			4b. City, Town, or Location of Death <b>Cumberland</b>	
4c. County of Death <b>Allegany</b>				
5. Social Security Number <b>220-10-7698</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
8. Date of Birth (Month, Day, Year) <b>09/12/1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
10a. State <b>MD</b>		10b. County <b>Allegany</b>	10c. City, Town or Location <b>Cumberland</b>	
10e. Street and Number <b>14100 Bedford Road, NE</b>			10f. Zip Code <b>21502</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	16b. Kind of Business Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Edward Evans Robinette</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Mae McCarty</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Gail C. Knotts/ Niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 Clearwater Drive, Ridgeley, WV 26753</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>12</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>	Date <b>08/22/2011</b>
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State <b>Cumberland, MD</b>	
22. Name and Address of Facility <b>Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502</b>				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>70 yrs</b>	
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of): <b>Coronary Artery Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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29b. Signature and title of certifier 		29c. License number <b>D0033280</b>	29d. Date signed (Month, Day, Year) <b>Aug 20, 2011</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 21502</b>			
31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28469

Reg. No.

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Rose Leonti</b>			2. Date of Death Month Day Year <b>August 17, 2011</b>	3. Time of Death 2:10 P M
4a. Facility Name (if not institution, give street and number) <b>Asbury-Solomons Health Care Center</b>			4b. City, Town, or Location of Death <b>Solomons</b>	
5. Social Security Number <b>089-07-1219</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.
8. Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Calvert</b>	10c. City, Town or Location <b>Solomons</b>
10e. Street and Number <b>11450 Asbury Circle, Apt. 222</b>			10f. Zip Code <b>20688</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Associate</b>	
17. Father's Name (First, Middle, Last) <b>Francisco Mignone</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elvira Nerino</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Carlson - Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6515 Long Beach Drive, St. Leonard, Maryland 20685</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>	Date <b>08-23-2011</b>
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657</b>	

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <b>COMPLICATIONS OF DEMENTIA</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>YEARS</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):	d. _____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RHEUMATOID ARTHRITIS</b>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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29b. Signature and title of certifier 	29c. License number <b>D26358</b>	29d. Date signed (Month, Day, Year) <b>August 18, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John H. Weigel, MD 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678</b>	
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>	32. Registrar's Signature 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28470

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August Day 7 Year 2011		3. Time of Death 6:05 PM
Carol S. Lusby				
4a. Facility Name (if not institution, give street and number)  8822 Erie Avenue		4b. City, Town, or Location of Death  North Beach		4c. County of Death  Calvert
5. Social Security Number  211-32-2616		6. Sex  1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)  69 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07-19-1942
Usual Residence of Decedent  MD Calvert		10c. City, Town or Location  North Beach		9. Birthplace (State or Foreign Country)  Pennsylvania
10a. State  MD		10b. County  Calvert		10d. Inside City Limits  1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number  8822 Erie Avenue		10f. Zip Code  20714		10g. Citizen of What Country?  USA
11. Marital Status  1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Secretary		16b. Kind of Business Industry  Public School
17. Father's Name (First, Middle, Last)  Alfred Satterthwait		18. Mother's Name (First, Middle, Maiden Surname)  Vera Elizabeth Barber		
19a. Informant's Name/Relationship (Type, Print)  Karen E. Lusby, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  P.O. Box 387, North Beach, MD 20714		
20a. Method of Disposition  1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory		Date 8/9/2011
21. Signature of Funeral Service Licensee  ► William R. Gour		22. Name and Address of Facility  Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736		20c. Location - City or Town, State  Alexandria, VA
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death  5 months		
a. <i>Locally advanced cervical cancer</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  ► <i>cert</i>		
29b. Signature and title of certifier		29c. License number  D56024		29d. Date signed (Month, Day, Year)  August 8 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kenneth L. Abbott 110 Hospital Road Suite 110 Prince Frederick MD 20678				
31. Date filed (Month, Day, Year)  AUG 10 2011		32. Registrar's Signature  ► <i>Deanna G. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28471

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>ELIZABETH A. LINE</i>			2. Date of Death Month 08 Day 16 Year 2011	3. Time of Death 0438 M
4a. Facility Name (if not institution, give street and number) 5 Mullen Lane			4b. City, Town, or Location of Death Lothian	
4c. County of Death Anne Arundel				
5. Social Security Number 218-82-7064	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/25/1959
Usual Residence of Decedent 10a. State Maryland			10b. County Anne Arundel	
10c. City, Town or Location Lothian			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 5 Mullen Lane			10f. Zip Code 20711	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Assistant		16b. Kind of Business Industry Medical
17. Father's Name (First, Middle, Last) Robert Walters			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Woods	
19a. Informant's Name/Relationship (Type, Print) David C. Line/ Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Mullen Lane, Lothian, Maryland 20711	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 8/19/11
21. Signature of Funeral Services Licensee <i>Mullen</i>			20c. Location - City or Town, State Edgewater, Maryland	
22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037				

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Off days year
<p>a. Due to (or as a consequence of): <i>Aspiration pneumonia</i></p> <p>b. Due to (or as a consequence of): <i>End stage M.S.</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>Michael J. LaPenta MD</i>		29c. License number D 21438	29d. Date signed (Month, Day, Year) August 16 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MICHAEL J. LAPENTA MD 445 Defense Hwy Annapolis MD 21401</i>				
31. Date filed (Month, Day, Year) AUG 18 2011		32. Registrar's Signature <i>Anna S. Parks</i>		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28472

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death	3. Time of Death	
	William H. Lefkoff				Month August 18, 2011 Day Year	4:08 A M	
Funeral Director	4a. Facility Name (if not institution, give street and number) Montgomery Hospice Casey House			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
	5. Social Security Number 098-03-1017	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 30, 1919	9. Birthplace (State or Foreign Country) New York
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Silver Spring 10e. Street and Number 3701 International Drive #648 10f. Zip Code 20906 10g. Citizen of What Country? United States						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. WW II	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Ink Chemist	16b. Kind of Business Industry Capitol Printing, Inc.		
	17. Father's Name (First, Middle, Last) Morris Lefkoff			18. Mother's Name (First, Middle, Maiden Surname) Nettie Sussman			
	19a. Informant's Name/Relationship (Type, Print) Rachel Mather, Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4625 Thornhurst Drive, Olney, MD 20832			
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery	Date 08/22/11	20c. Location - City or Town, State Adelphi, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	<p>a. End Stage Renal Disease Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal Bleed Hypertension Dementia						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29d. Date signed (Month, Day, Year) 8/18/11
	29b. Signature and title of certifier 			29c. License number R 143201			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, C.R.N.P., 6001 Muncaster Mill Road, Rockville, MD 20855						
State Registrar	31. Date filed (Month, Day, Year) AUG 19 2011		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transcript.

15/1

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28473

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		Bobby Jack Lawson		Month August Day 21 Year 2011		0315 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		1 Conley Court		Elkton		Cecil	
Funeral Director		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) March 23, 1934	9. Birthplace (State or Foreign Country) Georgia
		Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10a. State Maryland		10b. County Cecil		10e. Street and Number 1 Conley Court	
		10f. Zip Code 21921		10g. Citizen of What Country? United States			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1952- 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Electrician		16b. Kind of Business Industry Electrical	
		17. Father's Name (First, Middle, Last) Elijah Lawson		18. Mother's Name (First, Middle, Maiden Surname) Catherine Higgs			
		19a. Informant's Name/Relationship (Type, Print) Violet Lawson/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Conley Court, Elkton, MD 21921			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Delaware Veterans Memorial Cemetery		Date August 25, 2011	20c. Location - City or Town, State Bear, DE
		21. Signature of Funeral Service Licensee ► Kristen D. Evans		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): a. <i>Chronic obstructive pulmonary disease</i> b. <i>myocardial infarction</i> c. <i>Alzheimer's disease</i>		Approximate Interval Between Onset and Death	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		d.			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier ► Phen. M.D.		29c. License number D00 71747		29d. Date signed (Month, Day, Year) 8/24/11	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 W. Main Street, Elkton, MD 21921					
		31. Date filed (Month, Day, Year) AUG 24 2011		32. Registrar's Signature Lorraine J. Parker			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28474

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
FRANK ANTHONY LEPORE, SR.		Month AUGUST Day 22 Year 2011		14:45 PM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
UPPER CHESAPEAKE MEDICAL CENTER		BEL AIR		HARFORD	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.
222-10-1785		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	87 Yrs.	Months	Days Hours Min.
				OCT. 12, 1923	9. Birthplace (State or Foreign) BROOKLYN NEW YORK
Usual Residence of Decedent		10a. State MARYLAND 10b. County CECIL		10c. City, Town or Location NORTH EAST	
				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No XX	
10e. Street and Number		276 BAILIFF ROAD		10f. Zip Code 21901	10g. Citizen of What Country? UNITED STATES
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		If Yes, Give Year or Dates 1943-46		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry GOVERNMENT	
Elementary/Seconday (0-12) 12		College (1-4 or 5+) ARTILLERY REPAIRMAN			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
FRANK LEPORE		RACHAEL LAURIA			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
MARIE JACKSON / DAUGHTER		276 BAILIFF ROAD, NORTH EAST, MARYLAND 21901			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date AUGUST 26, 2011	20c. Location - City or Town, State WILMINGTON, DELAWARE
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		CATHEDRAL CEMETERY			
21. Signature of Funeral Director (see)		22. Name and Address of Facility		CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23c. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of): Respiratory failure		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): Pneumonia			
c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		End Stage Parkinson's		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D63420		29d. Date signed (Month, Day, Year) August 22, 2011	
29b. Signature and title of certifier Dr. John J. Khan, MD					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) AUG 25 2011		32. Registrar's Signature Janice S. Parker	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 28475

Reg. No.

1 - For  
State  
Registrar

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARY P LIPPINCOTT</b>				2. Date of Death Month <b>August</b> Day <b>13</b> , Year <b>2011</b>	3. Time of Death 4:00 P M		
	4a. Facility Name (if not institution, give street and number) <b>6807 Niles Drive</b>		4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince Georges</b>			
<b>Funeral Director</b>	5. Social Security Number <b>067-18-2714</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>March 23, 1924</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b> 10b. County <b>Prince Georges</b> 10c. City, Town or Location <b>Laurel</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6807 Niles Drive</b>			10f. Zip Code <b>20707</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Raymond Payton</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Egan Payton</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Farrington- daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5700 Goldfinch Court, Ellicott City, MD 21043</b>					
<b>Physician/ Medical Examiner</b>	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>unk</b>	20c. Location - City or Town, State <b>Arlington, Virginia</b>		
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <b>M. Payton 101234</b>		22. Name and Address of Facility <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>HEART FAILURE</b>						Approximate Interval Between Onset and Death <b>8 wks</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>EMPHYSEMA</b>						<b>10 years</b>	
	a. Due to (or as a consequence of): <b>HEART FAILURE</b>	b. Due to (or as a consequence of): <b>EMPHYSEMA</b>	c. Due to (or as a consequence of): <b></b>	d. <b></b>				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b></b>				23d. Date of delivery Month <b>Day</b> <b>Year</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension Atrial fibrillation</b>						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <b>1 Natural</b> <b>5 Pending Investigation</b> <b>2 Accident</b> <b>6 Could not be determined</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury <b>M</b>	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <b>1 Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>3 Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>R. Patel Desai, MD</b>		29c. License number <b>D-43417</b>		29d. Date signed (Month, Day, Year) <b>08/16/2011</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SWATI M. DESAI, RACC, 2480 LLEWELLYN AVE, FT. MEADE, MD</b>							
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>Laura S. Pace</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28476

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Ursula Santamaria Lopez</b>				2. Date of Death Month Aug. Year 18, 2011			3. Time of Death 1725 M
4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>213-83-4664</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) June 5, 1961	9. Birthplace (State or Foreign Country) <b>Mexico</b>
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Adelphi</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>9211 Tuckahoe Lane</b>				10f. Zip Code <b>20783</b>			10g. Citizen of What Country? <b>Mexico</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dental Assistant</b>			16b. Kind of Business Industry <b>Dental</b>
17. Father's Name (First, Middle, Last) <b>Vicente Santamaria</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Socorro Lopez</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Hernan Ramirez/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9211 Tuckahoe Lane Adelphi, Maryland 20783</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>			Date <b>8/20/2011</b>
21. Signature of Funeral Service Licensee 				20c. Location - City or Town, State <b>Beltsville, Md</b>			

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death			
<p><b>Metastatic Breast Cancer</b></p> <p>a. Due to (or as a consequence of):</p> <p>{</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>DDO 68681</b>				29d. Date signed (Month, Day, Year) <b>August 19, 2011</b>	
29b. Signature and title of certifier 							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Veerappan Alegarsamy MD 1500 Forest Glen Rd Silver Spring, Md</b>							
31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 5 per fh g919 9-16-11 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28477

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

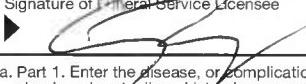
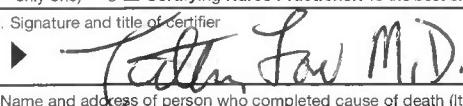
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Bonnie Bunn Laws</b>		2. Date of Death Month Day Year <b>AUGUST 17 2011</b>		3. Time of Death 1:24A M
4a. Facility Name (if not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>245-48-8908 8909</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 21, 1934</b>
9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Emmitsburg</b>
10e. Street and Number <b>334 Mountaineers Way</b>		10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 5+</b>		16b. Kind of Business Industry <b>Teacher Public High Schools</b>
17. Father's Name (First, Middle, Last) <b>Gaston Oris Bunn</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Mae Bass</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Marvin E. Laws / Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>334 Mountaineers Way, Emmitsburg, MD 21727</b>		
20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Crematory</b>		Date <b>August 18, 2011</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701</b>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>RECTAL CANCER</b>				
Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				
23b. If female: Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>				
24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29c. License number <b>D24034</b>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>8/17/2011</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TIMOTHY LOW, M.D. 7601 OSLER DRIVE TOWSON, MD 21204</b>				
31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28478

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Ide Laird

2. Date of Death

Month August Day 18 Year 2011

3. Time of Death

08:45 PM

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Pineview Future Care

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579-14-9256

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

December 6, 1920

9. Birthplace (State or Foreign Country)

Washington, DC

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

8625 Trumps Hill Rd.

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Seconday (0-12)  
12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Officer

16b. Kind of Business Industry

Banking

17. Father's Name (First, Middle, Last)

George Washington Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Frances Langral

19a. Informant's Name/Relationship (Type, Print)

Sandra Ducote (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8625 Trumps Hill Rd. Upper Marlboro, MD 20772

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

August 24, 2011 Brentwood, MD

21. Signature of Funeral Service Licensee M01555

Jessica Amrose

22. Name and Address of Facility Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd. Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Alzheimer's Dementia

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dorothy Seay

29c. License number

DOOS3337

29d. Date signed (Month, Day, Year)

August 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Seay 7835 Smith Avenue Ste 203 Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 22 2011

32. Registrar's Signature

Laura A. [Signature]

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 28479

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) TERRENCE DEE MORRIS				2. Date of Death Month AUGUST Day 14 Year 2011		3. Time of Death 12:00PM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) NATIONAL INSTITUTES OF HEALTH				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director		5. Social Security Number 225-15-4002		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/23/1977	9. Birthplace (State or Foreign Country) VA
To Be Completed by Funeral Director		10a. State MD		10b. County Prince George's		10c. City, Town or Location Fort Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		10e. Street and Number 1010 Palmer Rd, #8				10f. Zip Code 20744		10g. Citizen of What Country? United States	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business Industry Entrepreneur		16c. Kind of Business Industry Private	
		17. Father's Name (First, Middle, Last) Terri Caesar				18. Mother's Name (First, Middle, Maiden Surname) Janice Morris			
		19a. Informant's Name/Relationship (Type, Print) Joanne Morris/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2449 Spruce St., Norfolk, VA 23513			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 08/22/2011	20c. Location - City or Town, State Hampton, VA		
		21. Signature of Funeral Service Licensee ► <i>Beth A. Caesar 10/10/05</i>		22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747					
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 6 weeks			
		a. <i>Progressive multifocal leukoencephalopathy</i> Due to (or as a consequence of):							
		b. <i>Acquired immunodeficiency syndrome</i> Due to (or as a consequence of):				6 weeks			
		c. _____ Due to (or as a consequence of):							
		d. _____ Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: _____ 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier ► <i>Monica Ahei Lawrence</i>		29c. License number MD D00071618		29d. Date signed (Month, Day, Year) 08/14/2011			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monica Ahei Lawrence		10 CENTER DRIVE, BETHESDA, MARYLAND 20892					
		31. Date filed (Month, Day, Year) AUG 22 2011		32. Registrar's Signature <i>Monica Ahei Lawrence</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

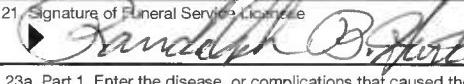
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28480

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mohammad Mazhar</b>					2. Date of Death Month <b>August</b> Day <b>17</b> , Year <b>2011</b>	3. Time of Death <b>2238 hrs.</b>
	4a. Facility Name (if not institution, give street and number) <b>Shady Grove Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>086-74-9250</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month <b>October</b> Day <b>20</b> , Year <b>1945</b>	9. Birthplace (State or Foreign Country) <b>Pakistan</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Germantown</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number <b>20334 Waters Row Terrace</b>			10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>4 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Restaurant General Manager</b>		16b. Kind of Business Industry <b>Restaurants</b>		
	17. Father's Name (First, Middle, Last) <b>Asmat Ullah</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rashida Begum</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Usman Mazhar (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12906 Clarksburg Square Road; Clarksburg, Maryland 20871</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Al-Firdaus Memorial Gardens</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Aug. 19, 2011</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee 			Name and Address of Facility <b>R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011</b>			
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	<p>a. Due to (or as a consequence of): <b>acute heart failure</b></p> <p>b. Due to (or as a consequence of): <b>chronic obstructive lung disease</b></p> <p>c. Due to (or as a consequence of): <b>Diabetes Mellitus</b></p> <p>d. Due to (or as a consequence of): <b>chronic renal disease</b></p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>Unknown</b>		23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary congestion</b>						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Residence</b>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>8/17/11</b>		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number <b>00057574</b>			
	29d. Date signed (Month, Day, Year) <b>8/17/11</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ahmed Heshmat, M.D.; 10301 Georgia Avenue; Suite 203; Silver Spring, Maryland 20902</b>						
	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

CR 1

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 perphyg 919 9-15-11 d.o.

State of Maryland / Department of Health and Mental Hygiene

2011 28481

Physician/  
Medical  
Examiner

For  
State  
Registrar

Funeral  
Director

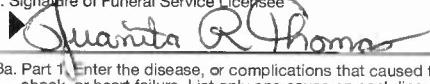
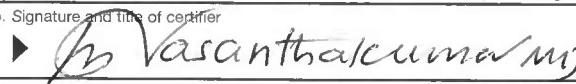
Baltimore, Maryland 21215-0036  
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once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certificate of Death			
Reg. No.			
1. Decedent's Name (First, Middle, Last) <b>Aleykutty P. Mathew</b> <b>Aleykutty P. Mathew</b>		2. Date of Death Month <b>August</b> Day <b>18</b> , Year <b>2011</b>	
3. Time of Death <b>3:45 P M</b>			
4a. Facility Name (if not institution, give street and number) <b>3327 Hibiscus Court</b>		4b. City, Town, or Location of Death <b>Ellicott City</b>	
4c. County of Death <b>Howard</b>			
5. Social Security Number <b>109-54-3638</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	
7. Age (In yrs. last birthday) <b>71</b> Yrs.		If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. State <b>MD</b>		10b. County <b>Howard</b>	
10c. City, Town or Location <b>Ellicott City</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3327 Hibiscus Court</b>		10f. Zip Code <b>21043</b>	
10g. Citizen of What Country? <b>United States</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian-Indian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b> <b>Registered Nurse</b>	
16b. Kind of Business Industry <b>University of MD Medical Center</b>			
17. Father's Name (First, Middle, Last) <b>Thommen Kuriakose</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Kuriakose</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Poulouse Mathew/husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3327 Hibiscus Ct Ellicott City, Maryland 21043</b>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>	
20c. Location - City or Town, State <b>Ellicott City, MD</b>		Date <b>8/22/2011</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Harry H. Witzke's Family, F.H.I.C. 4112 Old Columbia Pike Ellicott City, MD 21043</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>1 YEAR</b>	
a. <b>METASTATIC LUNG CANCER</b> Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number <b>D42510</b>		29d. Date signed (Month, Day, Year) <b>August 19, 2011</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. VASANTHAKUMAR 821 N EUTAW ST # 407 MD 21201</b>			
31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature 	

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 28482

1- For State Register

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Charles Martin</b>							2. Date of Death Month <b>August</b> Day <b>11</b> Year <b>2011</b>	3. Time of Death <b>0814 AM</b>	
	4a. Facility Name (if not institution, give street and number) <b>University of Maryland Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
<b>Funeral Director</b>	5. Social Security Number <b>219-58-7710</b>	6. Sex <b>XX</b> Male <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Dec 4, 1953</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>Lusby</b>							10d. Inside City Limits <input type="checkbox"/> Yes <b>2 XX</b> No		
	10e. Street and Number <b>50 Appeal Lane Suite 317</b>				10f. Zip Code <b>20657</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <b>XX</b>	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Seconday (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mason</b>				16b. Kind of Business Industry <b>Trade Construction</b>		
	17. Father's Name (First, Middle, Last) <b>William Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Copsey</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Chad Martin - Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9217 East Street, Owings, MD 20736</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Lee Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Date <b>Aug 13, 2011</b>	20c. Location - City or Town, State <b>Clinton, MD</b>			
	21. Signature of Funeral Service Licensee <b>Daryl J. Goff</b>				22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736</b>					
<b>Physician/ Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Sepsis</b>									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>						23d. Date of delivery Month Day Year	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>9 Unknown</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cirrhosis</b> <b>Hepatitis C</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <b>Dina Ismail</b>				29c. License number <b>D72344</b>			29d. Date signed (Month, Day, Year) <b>August 11, 2011</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dina Ismail 22 South Greene Street, Baltimore, Maryland 21201</b>									
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>AUG 16 2011</b>		32. Registrar's Signature <b>Dina Ismail</b>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

dew 2  
2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28483

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Preston Richard Milling, Sr.</b>			2. Date of Death Month <b>August</b> Day <b>12</b> , 2011 Year	3. Time of Death 9:00 A M
4a. Facility Name (if not institution, give street and number) <b>4559 Sixes Road</b>			4b. City, Town, or Location of Death <b>Prince Frederick</b>	
5. Social Security Number <b>214-28-9110</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
			8. Date of Birth (Month, Day, Year) <b>12/28/1928</b>	
			9. Birthplace (State or Foreign Country) <b>Maryland</b>	
10a. State <b>Maryland</b>			10b. County <b>Calvert</b>	10c. City, Town or Location <b>Prince Frederick</b>
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>470 West Dares Beach Road Apt. 209</b>			10f. Zip Code <b>20678</b>	10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>carpenter</b>		16b. Kind of Business Industry  <b>ship yard</b>
17. Father's Name (First, Middle, Last) <b>Richard A. Milling</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Genevieve Jones</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Debbie Largent - daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 234 Broomes Island Maryland 20615</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Rausch</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul Cemetery</b>	Date <b>August 16 2011</b>
21. Signature of Funeral Service Licensee <b>Rausch</b>			20c. Location - City or Town, State <b>Lusby Maryland</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <b>years</b>	
<p>a. <b>Lung cancer</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House</b>	
27. Manner of Death  <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b>		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>Arati C. Patel</b>			29c. License number <b>D59061</b>	
29d. Date signed (Month, Day, Year) <b>August 12, 2011</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Arati C. Patel, MD 110 Hospital Road, Suite 212, Prince Frederick, MD 20678</b>				
31. Date filed (Month, Day, Year) <b>AUG 15 2011</b>		32. Registrar's Signature <b>Arati C. Patel</b>		

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28484

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
  
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 10:50 A M
Elizabeth C. Mullikin		August 12, 2011		
4a. Facility Name (if not institution, give street and number) Asbury Health Care Center		4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert
5. Social Security Number 218-16-2068		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	8. Date of Birth (Month, Day, Year) 02/07/1925
9. Birthplace (State or Foreign Country) Washington, DC				
10a. State Maryland		10b. County Calvert	10c. City, Town or Location Solomons	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 11513 Emmanuel Way, #535		10f. Zip Code 20688		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business Industry School
17. Father's Name (First, Middle, Last) James Carroll		18. Mother's Name (First, Middle, Maiden Surname) Maria Bowers		
19a. Informant's Name/Relationship (Type, Print) Dennis H. Mullikin / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8662 Chesapeake Lighthouse Drive, North Beach, Maryland 20714		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 08/13/2011
20c. Location - City or Town, State Alexandria, Virginia				
21. Signature of Funeral Service Licensee Michael Kevin Hardin, Jr.		22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 2 weeks		
a. <i>METASTASES TO BONES AND LIVER</i> Due to (or as a consequence of): <i>CARCINOMA LEFT LUNG</i>				
b. <i>CARCINOMA LEFT LUNG</i> Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D19427		
29b. Signature and title of certifier <i>AT Munshi M.D.</i>		29d. Date signed (Month, Day, Year) August 12, 2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwarali T. Munshi, M.D. 130 Hospital Rd., Suite 300, Prince Frederick, MD 20678				
31. Date filed (Month, Day, Year) AUG 15 2011		32. Registrar's Signature <i>James G. Park</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28485

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		MILLER		2. Date of Death Month Day Year	3. Time of Death Hour Min.
ELIZABETH				8/11/2011	4:06 P M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
123 Dorsey Dr.		Edgewater		Anne Arundel	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
216-22-2667					
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) July 11 1921			
10a. State Maryland		10b. County Anne Arundel		9. Birthplace (State or Foreign Country) Maryland	
10c. City, Town or Location Edgewater		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 123 Dorsey Dr.		10f. Zip Code 21037		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business Industry Laundry Supervisor United States Naval Academy	
17. Father's Name (First, Middle, Last) Daniel T. Howard		18. Mother's Name (First, Middle, Maiden Surname) Cora Pulley			
19a. Informant's Name/Relationship (Type, Print) John R. Miller (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1991 Dominoe Rd. Annapolis, Md. 21401			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Memorial Park		Date 8-17-11	20c. Location - City or Town, State Annapolis, Md.
21. Signature of Funeral Service Licensee Larry J. Reese		22. Name and address of Facility Wm. Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): BREAST CANCER				Approximate Interval Between Onset and Death YEARS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier G.L. Taylor NLP				29c. License number R118703	
						29d. Date signed (Month, Day, Year) 8/12/2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE LIGHTFOOT-TAYLOR, 445 DEFENSE Hwy, Annapolis, MD 21401							
31. Date filed (Month, Day, Year) AUG 17 2011		32. Registrar's Signature Suzanne B. Barker					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28486

1- For State  
Registration #27 per MD, 8/24/11; BMW, MoCo

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Blanche Fiddle Miller</b>				2. Date of Death Month Day Year <b>August 16, 2011</b>	3. Time of Death 3:30 PM			
	4a. Facility Name (if not institution, give street and number) <b>Brighton Gardens</b>		4b. City, Town, or Location of Death <b>North Bethesda</b>		4c. County of Death <b>Montgomery</b>				
<b>Funeral Director</b>	5. Social Security Number <b>220-01-0902</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days Hours Min. <input type="checkbox"/>	If Under 24 Hrs. <input type="checkbox"/>	8. Date of Birth (Month Day Year) <b>March 6, 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>North Bethesda</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5505 Tuckerman Lane #357</b>			10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Owner</b>		16b. Kind of Business Industry <b>Food Distributing Comp.</b>				
	17. Father's Name (First, Middle, Last) <b>Julius Fiddle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Rifkovitz</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Ann Sherman/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11200 Farmland Drive, Rockville, Maryland 20852</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Judean Memorial Gardens</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		Date <b>08/19/2011</b>	20c. Location - City or Town, State <b>Olney, Maryland</b>			
<b>Physician/ Medical Examiner</b>	21. Signature of Funeral Service Licensee <b>► McGreenhut MO1597</b>		22. Name and Address of Facility <b>Edward Sagel Funeral Direction, Inc 1091 Rockville Pike, Rockville, Maryland 20852</b>						
<b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Coronary Artery Disease</b>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Advanced Dementia</b>								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier <b>► Alpana Goswami MD</b>		29c. License number <b>D-27660</b>		29d. Date signed (Month, Day, Year) <b>8/17/11</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alpana Goswami, MD 11125 Rockville Pike, Suite 110, Rockville, Maryland 20852</b>								
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>AUG 22 2011</b>		32. Registrar's Signature <b>Anna P. Gosal</b>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trust.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28487

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>Diane C. Moore</b>				2. Date of Death Month Day Year <b>August 10, 2011</b>			3. Time of Death 1600 hrs	
4a. Facility Name (if not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>			4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>578-98-9679</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>32 yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>Oct 25 1978</b>	9. Birthplace (State or Foreign Country) <b>D.C.</b>

**Funeral Director**

10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>					10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>
-------------------------------	------------------------------------	---	--	--	--	--	---

10e. Street end Number <b>3305 Booker Rd.</b>			10f. Zip Code <b>21403</b>			10g. Citizen of What Country? <b>USA</b>	
--	--	--	-------------------------------	--	--	---	--

11. Marital Status <b>1 X Never Married 2 <input type="checkbox"/> Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 X No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 X No specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>
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15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 Laborer</b>			16b. Kind of Business/Industry <b>Floor Covering Labor House</b>
--	--	---	--	--	---

17. Father's Name (First, Middle, Last) <b>Calvin F. Moore</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Bonita Massey</b>				
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19a. Informant's Name/Relationship (Type, Print) <b>Deitra Myers (Sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10246 Prince Place Upper Marlboro, Md. 20774</b>					
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20a. Method of Disposition <b>1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>		20b. Place of Disposition <b>National Crematory or other place</b>	Date <b>8-19-11</b>	20c. Location - City or Town, State <b>Laurel, Md.</b>		
--	--	---	------------------------	---	--	--

21. Signature of Funeral Service Licensee <b>Larry S. Reese</b>		22. Name and Address of Facility <b>Wright &amp; Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401</b>					
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**Baltimore, MD 21215-0036**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
---	--	--

Immediate Cause (Final disease or condition resulting in death) <b>a. Gunshot Wound of Torso</b> Due to (or as a consequence of):		
---	--	--

b. Due to (or as a consequence of):		
--	--	--

c. Due to (or as a consequence of):		
--	--	--

d. Due to (or as a consequence of):		
--	--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b> 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	--	--	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
			24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>

25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:				
--	--	--	--	--	--

27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b> 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury <b>Aug 10, 2011</b>	28b. Time of Injury <b>1311 hrs</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Subject was shot</b>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) Multi-Family Apt.</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4203 56th Avenue, Bladensburg, MD</b>

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>August 11, 2011</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD - Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>
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31. Date filed (Month, Day, Year) <b>AUG 17 2011</b>	32. Registrar's Signature <b>Leanne S. Jane</b>
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**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28488

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

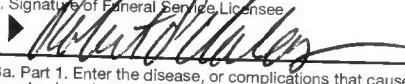
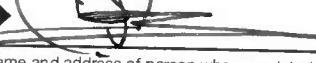
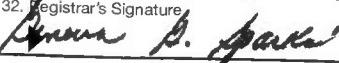
Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) <b>Margaret Jane Mulhern</b>		2. Date of Death Month Day Year <b>August 17, 2011</b>		3. Time of Death 2:50 A M
4a. Facility Name (if not institution, give street and number) <b>Gilchrist Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>193-16-7775</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates.
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>
10e. Street and Number <b>18 Upshur Avenue</b>			10f. Zip Code <b>21403</b>	
10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b> 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) <b>School Teacher</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
17. Father's Name (First, Middle, Last) <b>Martin James McEnrue</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Kane</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Edward J. Mulhern/ Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Upshur Avenue, Annapolis, Maryland 21403</b>		
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		Date <b>8/22/11</b>
21. Signature of Funeral Service Licensee 		20c. Location - City or Town, State <b>Annapolis, Maryland</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
<p>a. Due to (or as a consequence of): <b>Anoxic Brain injury</b></p> <p>b. Due to (or as a consequence of): <b>Ventricular Fibrillation</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>		Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b> 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Seizure</b> <b>Atrial Fibrillation</b>		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>		
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)</b> <b>Hospice</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b> 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <b>M</b>	28b. Time of injury <b>M</b>	28c. Injury at work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> <b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>D0071187</b>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>8-17-11</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Sheehan, 670 N. Charles St. Suite 4105, Baltimore, MD 21204</b>				
31. Date filed (Month, Day, Year) <b>AUG 18 2011</b>		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28489

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Teresa Moore</i>				2. Date of Death Month <u>8</u> Day <u>13</u> Year <u>2011</u>	3. Time of Death <u>1208 AM</u>		
	4a. Facility Name (if not institution, give street and number) <i>Shady Trauma Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <u>217-84-6486</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>51</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	8. Date of Birth Month <u>3</u> Day <u>19</u> Year <u>1960</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>		
To Be Completed by Funeral Director	10a. State <u>MD</u> 10b. County <u>Prince George's</u> 10c. City, Town or Location <u>Greenbelt</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <u>44-P Ridge Road</u>				10f. Zip Code <u>20770</u>	10g. Citizen of What Country? <u>United States</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>White</u>	14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
	15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Food Service Assistant</u>		16b. Kind of Business Industry <u>P.G. Public Schools</u>			
	17. Father's Name (First, Middle, Last) <u>Willard Amon Davis</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Dorothy Campbell</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Patrick L. Moore- Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>44-P Ridge Rd. Greenbelt, MD 20770</u>			
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Metropolitan Crematory</u>				Date <u>8/13/2011</u>	20c. Location - City or Town, State <u>Alexandria, VA</u>		
	21. Signature of Funeral Service Licensee <i>Ronald V.B. Borgwardt</i>				22. Name and Address of Facility <u>Borgwardt Funeral Home</u> <u>4400 Powder Mill Rd.</u> <u>Beltsville, MD 20705</u>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Severe Traumatic Brain Injury</i></p> <p>b. Due to (or as a consequence of): <i>SAN/SDH / Brainstem Infarct</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <u>  </u> <input type="checkbox"/> Unknown		23d. Date of delivery Month <u>  </u> Day <u>  </u> Year <u>  </u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury <u>M</u>	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <u>215197</u>		29d. Date signed (Month, Day, Year) <u>8/13/2011</u>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kathy L. Wild 2317 Selby ave Hyattsville, MD 20782</i>							
	31. Date filed (Month, Day, Year) <u>AUG 19 2011</u>		32. Registrar's Signature <i>Laura J. Spates</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached from the certificate and sent to the Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036.

Medical Certificate To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 28490

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nellie Elizabeth Marriner</b>					2. Date of Death Month Day Year <b>Aug. 19 2011</b>	3. Time of Death <b>8:17 pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>10710 Perryhawkin Church Rd.</b>			4b. City, Town, or Location of Death <b>Princess Anne</b>		4c. County of Death <b>Somerset</b>				
Funeral Director	5. Social Security Number <b>214-28-1763</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>102 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b></b>	If Under 24 Hrs. <b></b>	8. Date of Birth (Month, Day, Year) <b>Dec. 31, 1908</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>			
	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Somerset</b>			10c. City, Town or Location <b>Princess Anne</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>10710 Perryhawkin Church Rd.</b>			10f. Zip Code <b>21853</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 08</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Homemaker</b>		16b. Kind of Business/Industry <b>Domestic Engineer</b>						
	17. Father's Name (First, Middle, Last) <b>John E. Taylor</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ross Taylor</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Bettie Long- Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10710 Perryhawkin Church Rd. Princess Anne, Md.</b>		21853				
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Perryhawkin Cemetery</b>		Date <b>08-23-2011</b>	20c. Location - City or Town, State <b>Princess Anne, Md.</b>			
	21. Signature of Funeral Service Licensee <b>J. E. Taylor</b>			22. Name and Address of Facility <b>Hinman Funeral Home</b>		M00295 11673 Somerset Ave, Princess Anne, Md. 21853				
Physician /Medical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>months</b>		
	<p>a. Due to (or as a consequence of):  <i>hepatocellular carcinoma</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>		
								24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
								24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>						
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year) <b>M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>			
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29c. License number <b>D0059931</b>						
	29b. Signature and title of certifier <b>J. E. Taylor</b>			29d. Date signed (Month, Day, Year) <b>8/22/11</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Brett Hofmann 30434 Mt Vernon Rd Princess Anne Md 21853</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>			32. Registrar's Signature <b>Jenna A. Patel</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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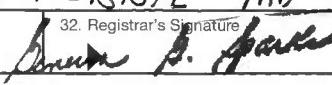
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 2849 |

## Certificate of Death

Reg. No.

1 - For State Registrar		2. Date of Death Month Day Year <b>August 20, 2011</b>						3. Time of Death 6:45 aM	
Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Fulvia Martella</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>1137 Hornell Drive</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>				
To Be Completed by Funeral Director		5. Social Security Number <b>214-74-2520</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 4, 1940</b>	9. Birthplace (State or Foreign Country) <b>Italy</b>	3. Time of Death 6:45 aM
		Usual Residence of Decedent 10a. State <b>MD</b>			10b. County <b>Montgomery</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>1137 Hornell Drive</b>			10f. Zip Code <b>20905</b>			10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 8</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Seamstress</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business Industry <b>Garment</b>		
		17. Father's Name (First, Middle, Last) <b>Silvio DiIanni</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Centrachio</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Teresa M. Mooney/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1135 Hornell Drive, Silver Spring, MD 20905</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gate of Heaven Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>Aug. 24</b>	20c. Location - City or Town, State <b>Silver Spring, MD</b>		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>					
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTASIS TO THE LIVER AND BONE</b>			Approximate Interval Between Onset and Death	
Medical Certificate: To Be Completed by Physician/Medical Examiner		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? <b>NO</b>			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier 		29c. License number <b>MD D50086</b>			29d. Date signed (Month, Day, Year) <b>8-22-11</b>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JEFFREY B. WETSTONE MD</b>		31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>			32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

2

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 28d, per me, g919 9-20-11 sm

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 28492

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Andres Chavez Melo	Month Aug. 16, 2011 Day Year	11:56 a M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
none	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	21 Yrs.	Months	Days	Month Day Year	Mexico

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	College Park	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5028 Geronimo Street	20740	Mexico

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican	Specify: White

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12	College (1-4 or 5+) Laborer	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anatolio Chavez Otero	Alberta Melo Rubio

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
COUSIN Rigoberto Rubio Rubio/	390 Bracking Trace Grayson, Georgia 30017

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	Municipal Cemetery of Jacala	8/27/2011	Jacala, Hidalgo, Mexico

21. Signature of Funeral Service licensee	PHOTO and Address
	PHILIP P. RINALDI FUNERAL SERVICE, P. A. 9241 Columbia Blvd. Silver Spring, MD 20910

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

## Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	
a. Due to (or as a consequence of):  <b>ANOXIC ENCEPHALOPATHY</b>	
b. Due to (or as a consequence of):  <b>ALCOHOL INTOXICATION</b>	
c. Due to (or as a consequence of):  <b>MULTIPLE ORGAN FAILURE</b>	
d.	

IF FEMALE:	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic Pregnancy 5 <input type="checkbox"/> Other (Specify)
			Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	08/13/2011	1:01 AM	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	<b>subject consumed alcoholic beverage</b>

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Home	5028 GERONIMO ST, MD-20740

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		D-50284	8/17/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHARMAY STRAMAY, MD, WASHINGTON ADVENTIST HOSP, TAKOMA PARK, MD-20912

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 23 2011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

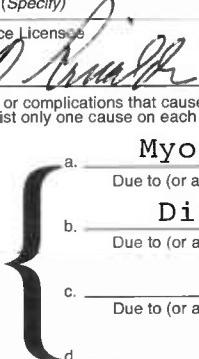
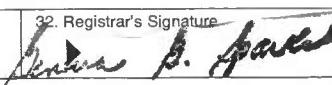
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28493

1- For  
State  
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Cristobal C Melgar</b>					2. Date of Death Month <b>August</b> Day <b>21</b> , Year <b>2011</b>	3. Time of Death 4:30p M	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>229 Grange Hall Drive</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>214-21-6042</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month, Day, Year) <b>6/11/1941</b>	9. Birthplace (State or Foreign Country) <b>El Salvador</b>	
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>229 Grange Hall Drive</b>			10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>El Salvador</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>El Salvadoran</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>	16b. Kind of Business/Industry <b>Research Co.</b>					
		17. Father's Name (First, Middle, Last) <b>Juan Melgar</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Santos Cuellar</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth Melgar/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>229 Grange Hall Drive Gaithersburg, Md 20877</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Souls Cem.</b>		Date <b>8/25/2011</b>	20c. Location - City or Town, State <b>Germantown, Md.</b>		
		21. Signature of Funeral Service Licensee 		<b>PHILIP D. RINALDI FUNERAL SERVICE, P.A.</b> <b>9241 Columbia Blvd. Silver Spring, Md 20910</b>					
Physician /Medical Examiner		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Medical Certification: To Be Completed by Physician/Medical Examiner		<p>a. <b>Myocardial infarction</b> Due to (or as a consequence of):</p> <p>b. <b>Diabetes</b> Due to (or as a consequence of):</p> <p>c. <b></b> Due to (or as a consequence of):</p> <p>d. <b></b> Due to (or as a consequence of):</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cirrhosis</b>							
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>FC0094704</b>					
		29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>August 22, 2011</b>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aaron Chidakel M.D. 806 West Diamond Ave #310 Gaithersburg, Md 20878</b>							
State Registrar		31. Date filed (Month, Day, Year) <b>AUG 23 2011</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2011 28494

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0844 hrs
Glenn Thompson Mitchell		August 25, 2011

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Ocean City	4c. County of Death Worcester
14102 Sailing Road		

**Funeral  
Director**

5. Social Security Number 214-56-2144	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 03/15/1950	9. Birthplace (State or Foreign Country) MD
--	--	---	---	---	---

**To Be Completed by Funeral Director**

10a. State MD	10b. County Worcester	10c. City, Town or Location Ocean City	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 14102 Sailing Road	10f. Zip Code 21842	10g. Citizen of What Country? USA
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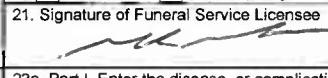
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	14. Race - American Indian, Black, White, etc.
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3	16b. Kind of Business/Industry Foreman
--	---	---

17. Father's Name (First, Middle, Last) George William Mitchell	18. Mother's Name (First, Middle, Maiden Surname) Marcea Thompson
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19a. Informant's Name/Relationship (Type, Print) Mary Louise Mitchell, wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14102 Sailing Road, Ocean City, MD 21842
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Carroll Cremation	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 08/27/2011	20c. Location - City or Town, State Hampstead, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 21157
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**Baltimore, MD 21215-0036**permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 2a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**Division of Vital Records, P.O. Box 68760,**To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death)	a. <b>Hypertensive Cardiovascular Disease</b> Due to (or as a consequence of):
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):
--	--

c. _____ Due to (or as a consequence of):	d. _____
--	----------

<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, 27, per me, g919 9-9-11 sm	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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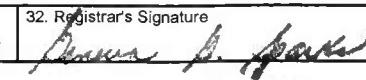
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 26, 2011
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30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) AUG 26 2011	32. Registrar's Signature 	OCME
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 19a per F.D. 08/24/2011 Carroll County, WI

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

2011 28495

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 7:30P M
Dorothy M Meinl	Aug 14 2011	
4a. Facility Name (If not institution, give street and number) Futurecare Cherrywood	4b. City, Town, or Location of Death Reisterstown	4c. County of Death Baltimore

Funeral  
Director

5. Social Security Number 220-05-7908	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 6-6-1917	9. Birthplace (State or Foreign Country) MD
--	--	---	---	--	--

Usual Residence of Decedent  
10a. State MD  
10b. County Carroll  
10c. City, Town or Location Manchester

10d. Inside City Limits  
1  Yes 2  No

10e. Street and Number  
2435 Mt. Ventus Rd. 2

10f. Zip Code  
21102

10g. Citizen of What Country?  
USA

To Be Completed by Funeral Director

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business Industry Administrator	

17. Father's Name (First, Middle, Last) Walter Cook	18. Mother's Name (First, Middle, Maiden Surname) Clara Mae
19a. In Case of Death, Name of Next of Kin (Type) <del>Cindy Willins Daughter</del> <del>Cindy Willins daughter</del>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2435 Mt. Ventus Rd. 2, Manchester, MD 21102

20a. Method of Disposition X <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley	Date 8-16-2011	20c. Location - City or Town, State Timonium, MD
21. Signature of Funeral Service Licensee ►	22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157		

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Due to (or as a consequence of): Senile dementia	Approximate Interval Between Onset and Death years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
------------------------------------	--

29b. Signature and title of certifier ►	29c. License number D37573	29d. Date signed (Month, Day, Year) August 15, 2011
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff Zirkel MD 2855 Smith Ave Baltimore MD 21209
--

31. Date filed (Month, Day, Year) AUG 16 2011	32. Registrar's Signature Anna S. Parker
--	---

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

WJS

1

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completely filled in by the

funeral director, page 2 should be

detached for use as the

burial-transit

slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 Amend #25, per ME g919 9/16/11 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28496

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death A.M./P.M.
Deborah Elaine Dalton Moser		August 11, 2011		9:41 A
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Meritus Medical Center		Hagerstown		Washington
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days Hours Min.
218-66-2981				
Usual Residence of Decedent		10a. State Maryland		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10b. County Washington		
10c. City, Town or Location Hagerstown		10f. Zip Code 21740		10g. Citizen of What Country? United States
10e. Street and Number 1743 Edgewood Hill Circle		10l. Zip Code 21740		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Hairdresser		16b. Kind of Business Industry Cosmetology
17. Father's Name (First, Middle, Last) William H. Dalton		18. Mother's Name (First, Middle, Maiden Surname) Judith Ballard		
19a. Informant's Name/Relationship (Type, Print) Adam Moser / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1743 Edgewood Hill Cir. Hagerstown, MD 21740		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory		20c. Date - City or Town, State Aug. 13, 2011 Frederick, Maryland
21. Signature of Funeral Service Licensee ►		22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): a. Exsanguinating Hemorrhage b. Upper Gastro-intestinal Bleeding 12 hours		Approximate Interval Between Onset and Death 2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. Due to (or as a consequence of): d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. State Respiratory Failure		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0071902		29d. Date signed (Month, Day, Year) August 12, 2011
29b. Signature and title of certifier ►		29c. License number D0071902		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark F. Sullivan, MD 11116 Medical Campus Road Hagerstown, MD 21742		31. Date filed (Month, Day, Year) AUG 19 2011		32. Registrar's Signature Anna S. Park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

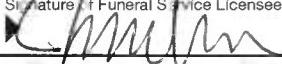
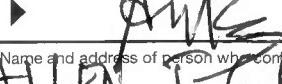
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28497

1 - For  
State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Frances Nisbet</b>							2. Date of Death Month Day Year <b>Aug 1, 2011</b>	3. Time of Death 3:11 PM M	
	4a. Facility Name (if not institution, give street and number) <b>Glade Valley Center</b>			4b. City, Town, or Location of Death <b>Walkersville</b>			4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>151-10-9957</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>95</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Hours <b> </b>	8. Date of Birth (Month Day Year) <b>Sep 14, 1915</b>	9. Birthplace (State or Foreign Country/Scotland) <b>Scotland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Frederick</b>				10c. City, Town or Location <b>Walkersville</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>56 W. Frederick Street Rm. 109-B</b>				10f. Zip Code <b>21793</b>		10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>			16b. Kind of Business Industry <b>Celanese Corp.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>James Nisbet</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Fitzpatrick</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Catherine Kolos</b> niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 334 Point of Rock MD 21777</b>						
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Scarpelli Funeral Home, P.A.</b>			Date <b>8/3/2011</b>	20c. Location - City or Town, State <b>Cresaptown MD</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>years</b>	
To Be Completed by Physician/Medical Examiner	<p>a. Due to (or as a consequence of): <b>Dementia</b> <b>Alzheimer's disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>August 2 2011</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALLEN J. WILSON, MD</b>		31. Date filed (Month, Day, Year) <b>AUG 11 2011</b> 32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2011 28498

18987  
Physician/  
Medical Examiner

**1- For State  
Registrar**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0854 hrs
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Ja'Den Terrill Nieves

Reg. No.

August 22, 2011

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Easton Memorial Hospital	4b. City, Town, or Location of Death Easton	4c. County of Death Talbot
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**To Be Completed by Funeral Director**

5. Social Security Number 824-48-4367	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 1 Months 26 Days Hours Min.	8. Date of Birth (MM/DD/YYYY) JUN 27 2011	9. Birthplace (State or Foreign Country) Maryland
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18987

**Usual Residence of Decedent**

10a. State MD	10b. County Talbot	10c. City, Town or Location St. Michaels	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 900 Talbot Street	10f. Zip Code 21663	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked	16b. Kind of Business/Industry N/A
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17. Father's Name (First, Middle, Last) Sheldon Terrill Nieves, Jr.	18. Mother's Name (First, Middle, Maiden Surname) Cierra Dawn Parsons
--	--

19a. Informant's Name/Relationship (Type, Print) Cierra Dawn Parsons	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Talbot Street St. Michaels, MD. 21663
---	--

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Richards Mem. Park	Date 8/30/11	20c. Location - City or Town, State Easton, Maryland
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21. Signature of Funeral Service Licensee Janelle C. Henry	22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washington st. Cambridge, MD. 21613
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	
--	--

c. Due to (or as a consequence of):	
--	--

d. Due to (or as a consequence of):	
--	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g920 10-14-11 sm
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 8-22-11	28b. Time of Injury fd 8:15 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred subject accidentally asphyxiated
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 Talbot St. Saint Michael, Md.
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 23, 2011
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) AUG 30 2011	32. Registrar's Signature Suzanne A. Brassell
--	--

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrars AMEND#26perMD, 8/19/11; BMW, MoC Certificate of Death

Reg. No. 2011 28499

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Yok Ying Ngai</b>		2. Date of Death Month Day Year <b>August 16 2011</b>		3. Time of Death 11:17 AM		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Civista Medical Center</b>		4b. City, Town, or Location of Death <b>La Plata</b>		4c. County of Death <b>Charles</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>579-02-9444</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Dec. 12, 1946</b>	9. Birthplace (State or Foreign Country) <b>China</b>
To Be Completed by Physician/Medical Examiner		10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certificate: To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>3908 Newman Court</b>		10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>USA</b>		
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <b>9</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Asian</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business Industry <b>Restaurant</b>		
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Zhou Jian Ni</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Xia Chen</b>				
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Stephen Cheng/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3908 Newman Court, Waldorf, MD 20602</b>				
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>[Signature]</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		Date <b>Aug. 21 2011</b>	20c. Location - City or Town, State <b>Rockville, MD</b>	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>				
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b>				Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{ Lung Cancer Liver Cancer Ovarian Cancer</b>						
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D0059232</b>		29d. Date signed (Month, Day, Year) <b>08/16/11</b>		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DeWayne Thompson MD S. Garrett Avenue La Plata, MD 20646</b>						
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <b>AUG 19 2011</b>		32. Registrar's Signature <b>[Signature]</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 28500

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

SS# 221-12-5978 8/21/11  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Owens, Elizabeth  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last) <b>Elizabeth Kincaid Owens</b>		2. Date of Death Month Day Year <b>August 21, 2011</b>		3. Time of Death <b>2023 M</b>
4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>221-12-5978</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>95 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Oct. 30, 1915</b>
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Perryville</b>
10e. Street and Number <b>16A Owens Landing Court</b>		10f. Zip Code <b>21903</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) Eleven Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Personal Residence</b>
17. Father's Name (First, Middle, Last) <b>Harry Vernon Kincaid</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth E. Hughart</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey A. Owens (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Penny Lane, Perryville, Maryland 21903</b>		
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hopewell Cemetery</b>		Date <b>08/25/11</b>
21. Signature of Funeral Service Licensee <b>John A. Patterson, Jr.</b>		22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home, P.A. Perryville, Maryland 21903-0766</b>		20c. Location - City or Town, State <b>Port Deposit, Maryland</b>
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):				
b. <b>MYASTHENIA GRAVIS</b> Due to (or as a consequence of):				
c. <b>PROGRESSIVE PROFOUND WEAKNESS</b> Due to (or as a consequence of):				
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>				
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>DOB 69118 8-22-11</b>		
29b. Signature and title of certifier <b>Khalid Puthawala</b>		29c. License number <b>MD 501 S. UNION AVE HAVRE DE GRACE, MD 21078</b>		29d. Date signed (Month, Day, Year) <b>8-22-11</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KHALID PUTHAWALA, MD 501 S. UNION AVE HAVRE DE GRACE, MD 21078</b>		31. Date filed (Month, Day, Year) <b>AUG 25 2011</b>		
32. Registrar's Signature <b>Conrad J. Park</b>				

ORIGINAL